

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7262

## CERTIFICATE OF DEATH

Reg. Dist. No. 07173

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>8 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Bailey</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>hosp. records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>and Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>60</u> , to <u>June 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theo. Zegarra, M.D.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, M.D. Riverdale, P. G., Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 14 1960</u>	<u>Culpeper Park</u>	<u>Pr</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. George Sosa</u> ADDRESS <u>Hyattsville Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Evans</u>

CERTIFICATE OF DEATH

1968

42

<p>1. Name of deceased: <u>John J. Smith</u></p>	
<p>2. Date of death: <u>10/15/68</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age: <u>65</u> years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of death: <u>Heart Disease</u></p>	
<p>10. Date of burial: <u>10/17/68</u></p>	
<p>11. Place of burial: <u>St. John's Cemetery</u></p>	
<p>12. Signature of physician: <u>[Signature]</u></p>	
<p>13. Signature of registrar: <u>[Signature]</u></p>	

7203

CERTIFICATE OF DEATH

07174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Princes Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>70 College Park</b>	
f. STREET ADDRESS <b>9004 51st Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Michael</b> First <b>Joseph</b> Middle <b>Robert</b> Last <b>Baker</b> <b>111</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/60</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Baker Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mildred C. Dement</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>780.0</b> <b>fulmonary embolism</b> DUE TO <b>idiopathic pulmonary embolism (?)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>idiopathic pulmonary embolism (?)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>June 13</b> , 19 <b>60</b> , to <b>June 15</b> , 19 <b>60</b> that I last saw the deceased alive on <b>June 15</b> , 19 <b>60</b> , and that death occurred at <b>6:30 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6905 Baltimore Ave.</b> DATE SIGNED <b>6/16/60</b> ACTUAL SIGNATURE <b>Thomas A. Christensen</b> M.D. PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen</b> <b>College Park, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gaseh's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1960</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

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P. Carson's home, Fayetteville, Mo.

Special Agents Mr. Oliver Lowmery, Washington, D.C.

James A. Thompson

NEW YORK, N.Y.

June 12, 1934

## CERTIFICATE OF DEATH

Reg. Dist. No.

07175

7204

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>12 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>209 Good Luck Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>E</b> Last <b>Baldwin</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-4-12</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trailer Truck</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James B Baldwin</b>		14. MOTHER'S MAIDEN NAME <b>Annie E Soper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Annie E Baldwin</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-20</b> 19 <b>60</b> to <b>6-20</b> 19 <b>60</b> that I last saw the deceased alive on <b>6-20</b> 19 <b>60</b> , and that death occurred at <b>7:30pm</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Wollcot L. Etienne MD.</b>		ADDRESS (Street, city or town, state) <b>College Park, Md.</b> DATE SIGNED <b>6/20/60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wollcot L. Etienne MD.</b>		M.D. <b>4713 - Berwyn St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 60</b>		DATE <b>JUN 24 60</b>	
24b. REGISTRAR'S SIGNATURE		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7268

Reg. Dist. No. 07176

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-CAMP SPRINGS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
c. LENGTH OF STAY IN 1b <b>70 minutes</b>				d. STREET ADDRESS <b>4530 FAIRFAX ROAD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHERYL ANN BARNES</b>				4. DATE OF DEATH Month Day Year <b>JUNE 25 1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGROID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 JUNE 60</b>		9. AGE (In years last birthday) <b>0</b> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min. <b>1 10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>EUGENE W. BARNES JR.</b>				14. MOTHER'S MAIDEN NAME <b>PATRICIA A. BARNES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>FATHER-ITEM 13</b>		Address <b>4530 FAIRFAX ROAD, BALTIMORE 16, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atelactasis, congenital</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>70 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 June, 1960</b> , to <b>25 June, 1960</b> , that I last saw the deceased alive on <b>25 June, 1960</b> , and that death occurred at <b>2215</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MD.</b> DATE SIGNED <b>25 JUNE 1960</b>							
ACTUAL SIGNATURE <b>John A. Moore</b>				M.D. <b>USAF HOSPITAL ANDREWS, 25 JUNE 1960</b>			
PHYSICIAN'S NAME (Type) <b>JOHN A. MOORE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-30-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. F. Taylor</b> ADDRESS <b>909 6th St N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050221XV4





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14, 22 Film 6269 6-17-60 et

## CERTIFICATE OF DEATH

07177

Reg. Dist. No.

7269

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews AFB</u> c. LENGTH OF STAY IN b. <u>36 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hosp Andrews-</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS <u>Idlewood Mobile Manor</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Baby Boy-</u> Middle <u>Benton</u> Last <u>Benton</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>4</u> Year <u>1960</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Cauc.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3 June 60</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>—</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>			
<b>13. FATHER'S NAME</b> <u>Floyd G. Benton</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Betty L. Wilcox</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Hosp chart.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that I attended the deceased from</b> <u>0800 4 June 1960</u> , to <u>2000 4 June 1960</u> , that I last saw the deceased alive on <u>8:12 PM</u> , 19 <u>60</u> , and that death occurred at <u>8:19 PM</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Salvatore Battiatto</u> M.D.			<b>ADDRESS</b> (Street, city or town, state) <u>USAF Hosp Andrews</u>				
<b>PHYSICIAN'S NAME</b> (Type) <u>SALVATORE BATTIATA, CAPT USAF MC</u>			<b>DATE SIGNED</b> <u>4-6-60</u>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>22b. DATE THEREOF</b> <u>6-6-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>D. C. Morgue</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Washington, D.C.</u>		<b>22e. (State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrews Air Force Base</u>			<b>ADDRESS</b>				
<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUN 9 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050202XV3

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07178

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>7979 Walker Mill Road</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alfred</b> Middle <b>Berry</b> Last		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>26</b> Year <b>19 60</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-26-16</b>
<b>9. AGE</b> (In years last birthday) <b>44</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Washington Berry</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Rebecca Dunnington</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Matilda Berry; same address as #2.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Acute congestive heart failure</b> <b>421.4</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>Chronic valvular heart disease</b> <b>DUE TO</b> <b>(c)</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i>		<b>DATE SIGNED</b> <b>June 26, 1960</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <b>6-30-60</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St Marys Ch. Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Croome Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>H.S. Washington</i>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 29 '60</b>	
<b>ADDRESS</b> <b>4925 Deane Ave N.E.</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Pinner</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

22

7270

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>	c. LENGTH OF STAY IN 1b <u>16 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Switland Nursing Home</u>		d. STREET ADDRESS <u>13220 Chillum Rd. #202</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET J. BEVANS</u>		4. DATE OF DEATH Month Day Year <u>6-12-1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-86</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles H. Bevans</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Ashford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-22-2407</u>	
17. INFORMANT <u>Ruby Beyer</u>		Address <u>2220-Geo St. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral thrombosis with</u> DUE TO <u>Cerebral thrombosis with</u> (c) <u>Cerebral thrombosis with</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-1-1960</u> to <u>6-12-1960</u> that I last saw the deceased alive on <u>6-12-1960</u> and that death occurred at <u>4:07 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D.		DATE SIGNED <u>6-12-60</u>	
PHYSICIAN'S NAME (Type) <u>DAVID S. GORDON</u>		<u>5731-23rd Parkway Hillcrest Heights, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-15-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber G. Inc.</u> ADDRESS <u>517-11th St. S.E.</u>		24a. REC'D BY REGISTRAR <u>DAVID 16 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

125



07180

## CERTIFICATE OF DEATH

Reg. Dist. No.

7194

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5825 32ND AVE</u>				e. STREET ADDRESS <u>5825 32ND AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Veronica</u> Last <u>Blake</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 12, 1912</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>PHILA. PENN'A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. - 1.</u>							
13. FATHER'S NAME <u>JOHN RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH McDONALD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>209-26-8467</u>		17. INFORMANT <u>MICHAEL H. BLAKE</u> Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon (rectum)</u> 31 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 18</u> 19 <u>60</u> , to <u>June 22</u> 19 <u>60</u> , that I lost saw the deceased alive on <u>June 7</u> 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>6-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	
22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Riverdale, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in blank in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME (1)  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

7206

07181

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>Marlboro Pike S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Delle</b> Middle <b>Burroughs</b> Last <b>June</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-12-1900</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		9. AGE (In years last birthday) <b>60</b> yrs.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>16 X</b>				17. INFORMANT <b>Fred. Burroughs, same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of the skull</b> (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Compound fractures of both distal end of femurs</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>MV - M</b>			
20c. TIME OF INJURY Month, Day, Year <b>7:00 p.m. 6/25/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State Road</b>		20f. (City or town) (County) (State) <b>Forestville P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-29-60</b>				22b. DATE THEREOF <b>6-29-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Catholic Church</b>				22d. LOCATION (City, town, or country) (State) <b>Pomfret, Charles C. Md.</b>			
23. FUNERAL DIRECTOR <b>Myrtle R. Rollins</b>				24. REGISTRAR'S SIGNATURE <b>Rollins Turner</b>			
25. REGISTRAR'S SIGNATURE <b>Rollins Turner</b>				26. REGISTRAR'S SIGNATURE <b>Rollins Turner</b>			

JUN 29 '60

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

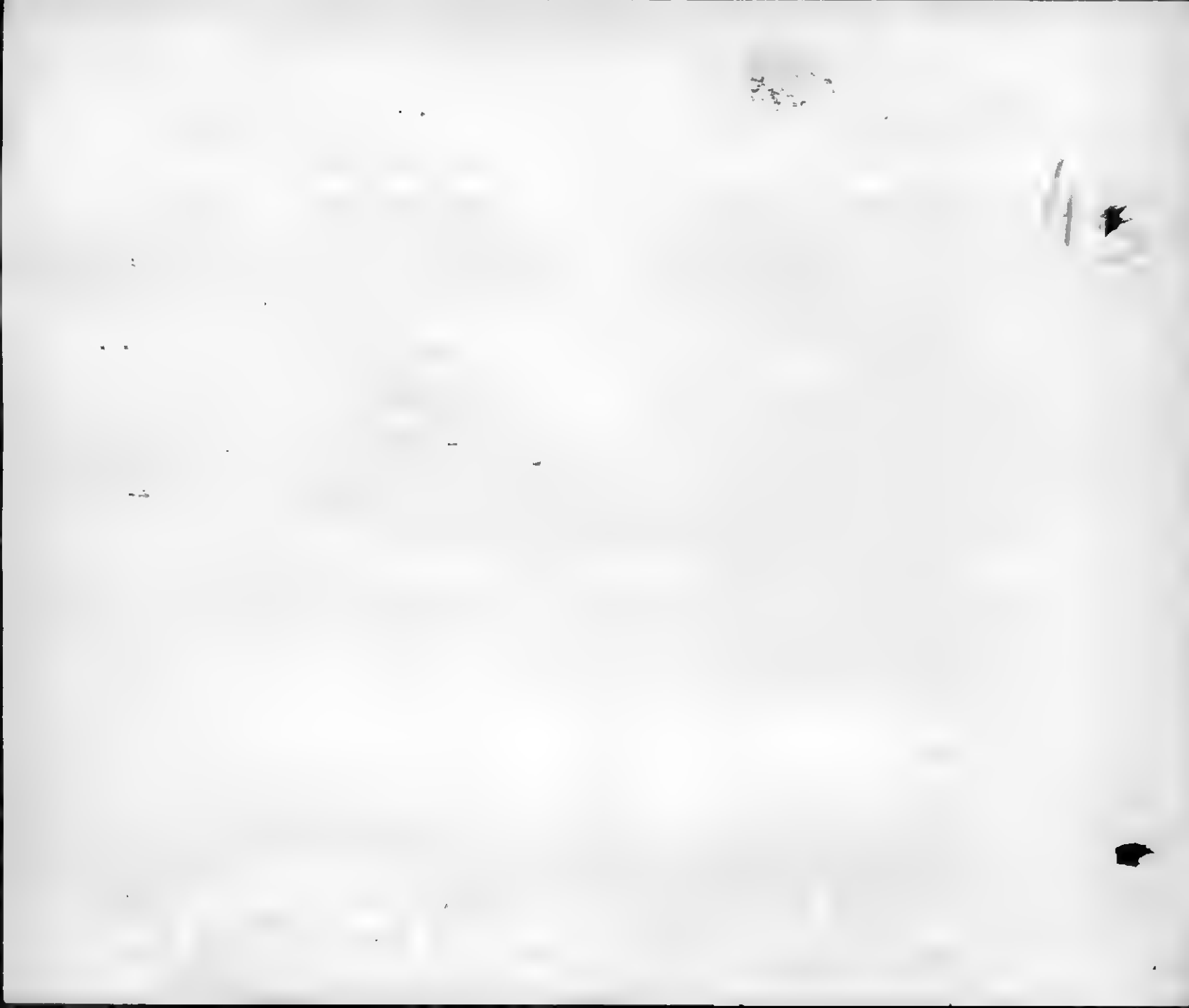
**7207**

**07182**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>0</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 North Brentwood</b>			
				d. STREET ADDRESS <b>4521 Banner Street</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Byrd</b> Last <b>Byrd</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>B</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>47</b> Days <b>13</b> Hours <b>13</b> Min.		IF UNDER 24 HRS Months <b>47</b> Days <b>13</b> Hours <b>13</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William Jones</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Reed</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Husband - Clyde Byrd</b>	
				Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> <b>4700</b> DUE TO <b>CONGESTIVE THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost the deceased alive on <b>19</b> , and that death occurred at <b>19</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Norman Donat Cmeall</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT CMEALL</b>				22d. ADDRESS <b>3503 PENNY ST MT RAINIER MD</b>			
23a. BURIAL, CREMATATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-16-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery, B.C.</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leroy C. Berry - Huntington, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

**M**

Released by Dr. J. MALONE & CO. LANCET Page 4  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





7271

## CERTIFICATE OF DEATH

Reg. Dist. No. 07183

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie Md. 1440.				c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6 Yrs. 25 Boulevard Hyt.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 14905 Byrd St. S.E. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ernestine K. Calhoun				4. DATE OF DEATH Month Day Year 6 21 1960			
5. SEX 7		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 1. 1875	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Hungary				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Krawcz.				14. MOTHER'S MAIDEN NAME Geraldine Kramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 3			
17. INFORMANT Address Selma Calhoun 4905 Byrd St. S.E.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure							28 hrs.
DUE TO (b) Arteriosclerotic Heart Disease							6 months
DUE TO (c) Arteriosclerotic Hypertensive C.V. Disease							10 Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis Chronic Heart Patient 1457 Political Machinery							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-1-1960, to 6-21-1960, that I last saw the deceased alive on 6-21-1960, and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John J. Calarco				ADDRESS (Street, city or town, state) DATE SIGNED 3801 S. Highland Rd. S.E. 6-21-60			
PHYSICIAN'S NAME (Type) John L. Calarco M.D.				Washington 20, D.C.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATOR		22d. LOCATION (City, town, or county) (State)	
Burial 6/1/60		6/1/60		GEO. WASH. CEM.		HYATTSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Address				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Charles H. Hume 4217-9th Ave				DATE JUN 22 '60		Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07184  
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 N. Brentwood</b> d. STREET ADDRESS <b>4552 41st Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alice</b> Middle <b>Marie</b> Last <b>Campbell</b> <b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>5</b> Year <b>19 60</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>colored</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>August 10, 1915</b> <b>9. AGE</b> (In years last birthday) <b>44 yrs.</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Charwoman</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Sanitary Commission</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
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<b>13. FATHER'S NAME</b> <b>Joseph Cooper</b>	<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Clarence V. Campbell; same address as # 2.</b> Address

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Stab wound of heart</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed in chest by another person. Operation. Expired on table</b>		
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>8:45 a.m. 6-4-60 19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home. Out doors. Brentwood, Pr. Geo. Md.</b>	<b>20f. (City or town)</b> (County) (State)

**21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.**

<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>	<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>June 5, 1960</b>
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<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>6.9.60</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Lincoln Mem. Cemetery</b>	<b>22d. LOCATION (City, town, or county)</b> (State) <b>Suitland Maryland</b>
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<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Robert M. Smith</i> <b>ADDRESS</b> <b>1420 9th St. Wash. DC</b>	<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUN 7 '60</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Frank</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

45

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07185

7209

Item 9 Film 4266 7/5/60 1wk

1 PLACE OF DEATH a. COUNTY <b>Prince Georges General</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Res'dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>W</b> Last <b>Carter</b>		4 DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Black</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5 Aug. 1898</b>
9 AGE (In years last birthday) <b>61 62</b> y's		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11 BIRTHPLACE (State or foreign country) <b>Md</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13 FATHER'S NAME <b>Unknown</b>	
14 MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO		17. INFORMANT Address <b>Louise Carter Wesley St. Glen Arden Md</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intracerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemorrhage left internal capsule</b> DUE TO (c) <b>Cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>12 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>26 June 19 60</b> to <b>26 June 19 60</b> that (I) (we) last saw the deceased alive on <b>26 June 19 60</b> and that death occurred on <b>5, 19 60</b> from the causes and on the date stated above		
22a SIGNATURE <b>George Hageage</b>	M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b DATE SIGNED <b>6-26-60</b>
22c PHYSICIAN'S NAME (Type) <b>Dr. Geo. Hageage., M.D.</b>	22d ADDRESS <b>Mt. Rainier., Md</b>	
23a BURIAL (CREMATION, REMOVAL) (Specify) <b>6-29-60</b>	23b. DATE THEREOF <b>6-29-60</b>	23c NAME OF CEMETERY OR CREMATORY <b>Holy Family Cem.</b>
23d. LOCATION (City, town or county) (State) <b>Woodmoor, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>H S Washington Sons</b>
25a REC'D BY REGISTRAR <b>ONE 11E</b>		25b REGISTRAR'S SIGNATURE <b>ONE 11E</b>

25



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7272

CERTIFICATE OF DEATH

07186  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR. Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>4. 3. 2. 1.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FORESTVILLE NURSING HOME-2118-15 St S.E.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>M.</u> Last <u>CASSADAY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1st</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-27-1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Clifton Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James C. Kincheloe</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year or not unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>J. Jacob Kincheloe</u>		INFORMANT Address <u>Fairfax Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>1 week</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Incorrected arteriosclerosis 5 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>6-1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-31-60</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2210 Lakeside Ave. N.E. Washington D.C.</u> DATE SIGNED <u>John B. Jagan</u>							
ACTUAL SIGNATURE <u>John B. Jagan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ICAN 15 FEGA</u> <u>2210 Lakeside Ave. N.E. Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 3-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Clifton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clifton Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS</u>		23a. ADDRESS <u>1601 Good Hope Wash. D.C. ROSE</u>		23b. RECEIVED BY REGISTRAR <u>DATE JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1420 a 10 000

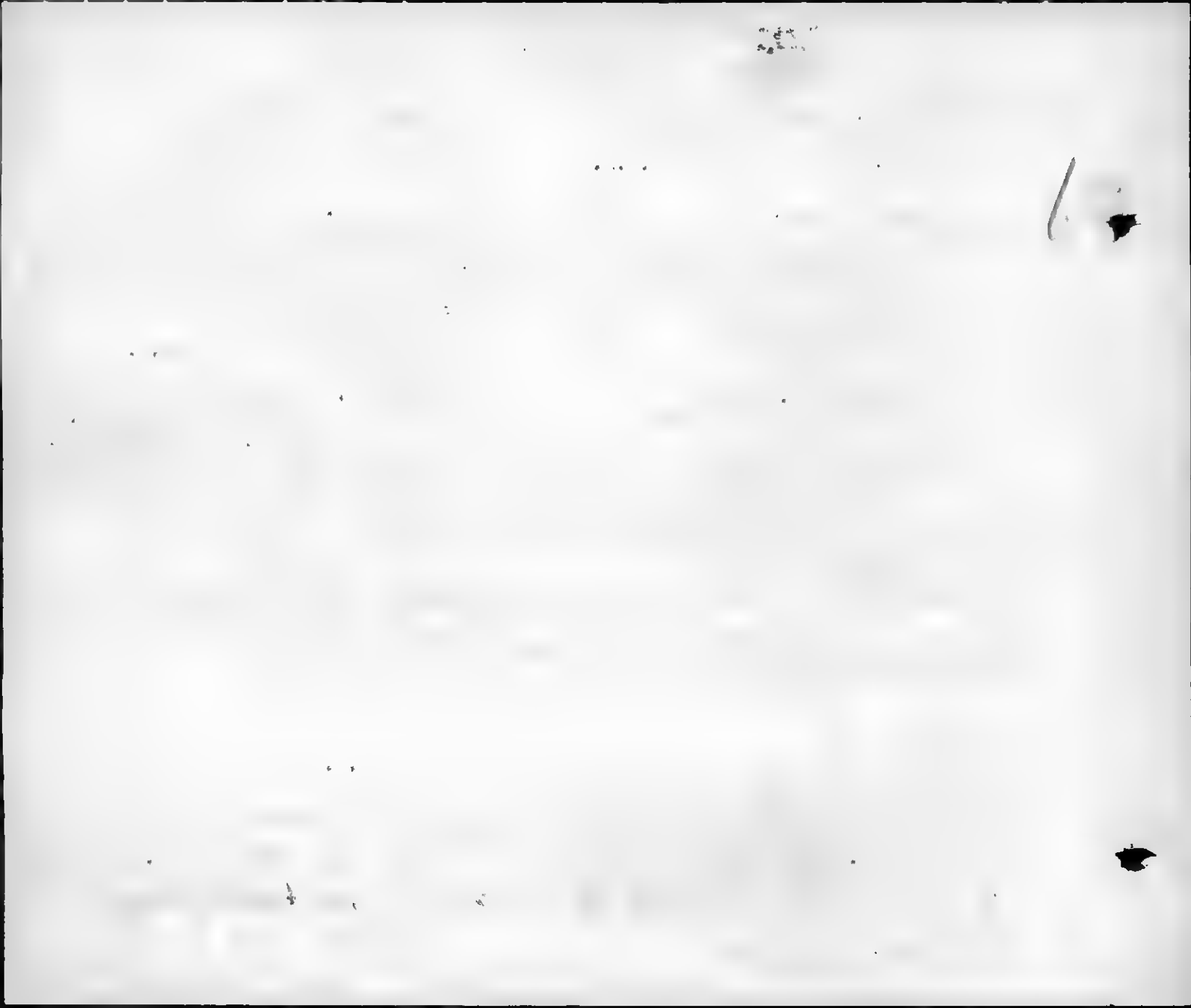
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**7210**

**07187**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Princes Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>8911 59th Ave.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Kevin</b> Middle <b>Paul</b> Last <b>Cavalin</b>				<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1959</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Vincenzo G. Cavalin</b>				14. MOTHER'S MAIDEN NAME <b>Elenore I. Rolfsema</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Father</b>		Address <b>Md.</b> <b>8911 59th Ave., Berwyn Heights,</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1-34.1</b> DUE TO <b>Interstitial pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cong. Hh. Db.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1959</b> to <b>June 1960</b> , that (I) (we) last saw the deceased alive on <b>June 6 1960</b> , and that death occurred <b>10:35 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Hans Wodak</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Hans Wodak</b>				22d. ADDRESS <b>30 C Ridge Road, Greenbelt, Md.</b>			
23a. BURIAL CREMATION, ETC. (Specify)		23b. DATE THEREOF		23c. PLACE OF BURIAL OR CREMATION		23d. DATE OF BURIAL OR CREMATION	
<b>BURIAL</b>		<b>6/13 /60</b>		<b>Mt. Olivet Cemetery, Washington, D.C.</b>		<b>June 14 '60</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gieseke Sons Hyattsville Md</b>				25a. RECEIVED BY REGISTRAR DATE <b>JUN 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



CERTIFICATE OF DEATH

Reg. Dist. 07188

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Bowie)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home (Bowie Md.)</u>		d. STREET ADDRESS <u>Bowie Md</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Chittams</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1896</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Contee</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Chittams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>John Aubrey Brown</u>	
17. INFORMANT <u>Bowie Md</u>		Address <u>Bowie Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Illnesses Incident to Old Age</u> 794-X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>60</u> to <u>June 17</u> 19 <u>60</u> , that I last saw the deceased alive on <u>June 16</u> 19 <u>60</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Henry A. Wise Jr.</u> M.D. <u>149 9th St</u> <u>Bowie Md</u>		ADDRESS (Street, city or town, state) <u>617 1/2 St</u> DATE SIGNED <u>June 22 '60</u>	
PHYSICIAN'S NAME (Type) <u>Henry A. Wise Jr.</u>		<u>149 9th St</u> <u>Bowie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-21-60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Aurison Church</u>	22d. LOCATION (City, town, or county) (State) <u>Bowie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Washington</u> ADDRESS <u>4925-Neane Ave NE</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>
		DATE <u>JUN 22 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. 07189

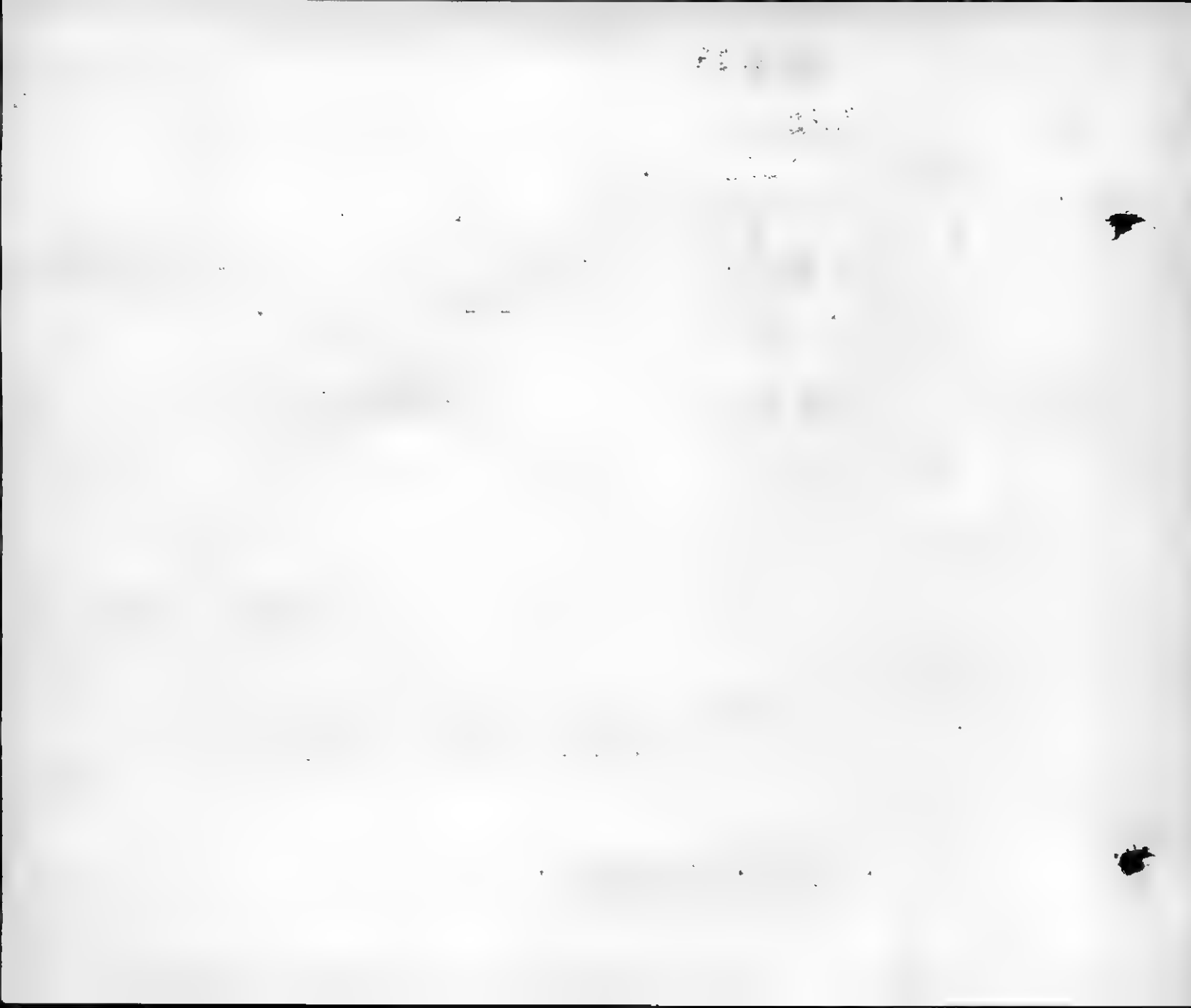
7211

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
c. LENGTH OF STAY IN 1b <u>2 da.</u>		d. STREET ADDRESS <u>Rt. 1 Box 1410</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl Clark</u>		4. DATE OF DEATH Month Day Year <u>June 13 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-60</u>
9. AGE (In years lost birthday) <u>2 da.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clinton Clark</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Alvira Burkhardt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>H usband</u>	
17. ADDRESS <u>Same as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>prematurity (1 lb 4 oz)</u> 762.5 DUE TO (b) <u>atelektasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>60</u> , to <u>June 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>60</u> , and that death occurred at <u>1:00 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cheverly, Maryland</u> DATE SIGNED <u>6/13/60</u>			
ACTUAL SIGNATURE <u>Thomas A. Christenson</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Thomas A. Christenson MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's General</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Penn, Jr.</u>		24a. REC'D BY REGISTRAR <u>Admin</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		DATE <u>JUN 22 1960</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville - Adelphi</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Twain Branch Nursing Home</u>		e. STREET ADDRESS <u>4913 Edenwood Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Fred Everett Clark</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph H. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Alice Hornbeck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>094-10-5463</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7</u> , 19 <u>60</u> , to <u>6-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>60</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward H. Pearson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>June 11/1960</u>	
PHYSICIAN'S NAME (Type) <u>Dr. T. L. Nelson</u>		M.D. <u>Arthur L. Hume</u>	
22a. BURIAL CREMATION, 22b. DATE THEREOF <u>Removed Burial 6/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fantinkill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Ellenville Ulster N.Y.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch &amp; Sons</u> ADDRESS <u>Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191

Reg. Dist. No.

7257

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>5 months</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02. Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1515 Sandy Spring Road Warren Hosp.</b>		d. STREET ADDRESS <b>1515 Sandy Spring Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Katherine Marie</b> Middle <b>Clayman</b> Last		<b>4. DATE OF DEATH</b> Month <b>June 14,</b> Day <b>1960</b> Year <b>19</b>	
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>January 7, 1960</b>
<b>9. AGE</b> (In years last birthday) <b>5</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>5</b> Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George Neal Clayman</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ida Mae Helms</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>George N. Clayman</b>		Address <b>Laurel, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> DUE TO <b>921.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration of food</b> (c), stating the underlying cause last, DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. EXTENSIONAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Aspiration of food</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>1:30 a. m. 6/14/60 19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
<b>20f. (City or town)</b> <b>Laurel</b>		<b>(County)</b> <b>Pr. Geo.</b>	
<b>(State)</b> <b>Maryland</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <b>John T. Maloney</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney</b>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>June 14, 1960</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>June 16, 1960</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenwood Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> <b>Baistown, Prince George's County, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William J. Connelley</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 20 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay. This certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07192

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Princes Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 da,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>41 Radiant Valley</b>	
3. NAME OF DECEASED (Type or print) <b>Lena Cohen</b>		4. DATE OF DEATH <b>June 25 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1878</b>
9. AGE (In years last birthday) <b>81</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Herman Baer</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Charles L. Cohen Radiant Valley Md</b>	
17. INFORMANT <b>Charles L. Cohen Radiant Valley Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Intraventricular hemorrhage</b> DUE TO (b) <b>Hemorrhage right internal capsule</b> DUE TO (c) <b>Cerebral arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-22</b> 19 <b>60</b> , to <b>6-25</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:30 pm</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>George Hageage</b>		22b. DATE SIGNED <b>6-25-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Hageage MD.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbington Hebrew</b>		23d. LOCATION (City, town, or county) (State) <b>N. Arlington New Jersey</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gesche Sons Hyattsville Md</b>		25a. REGISTERED BY REGISTRAR <b>SUN 25 60</b>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

2011

41

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

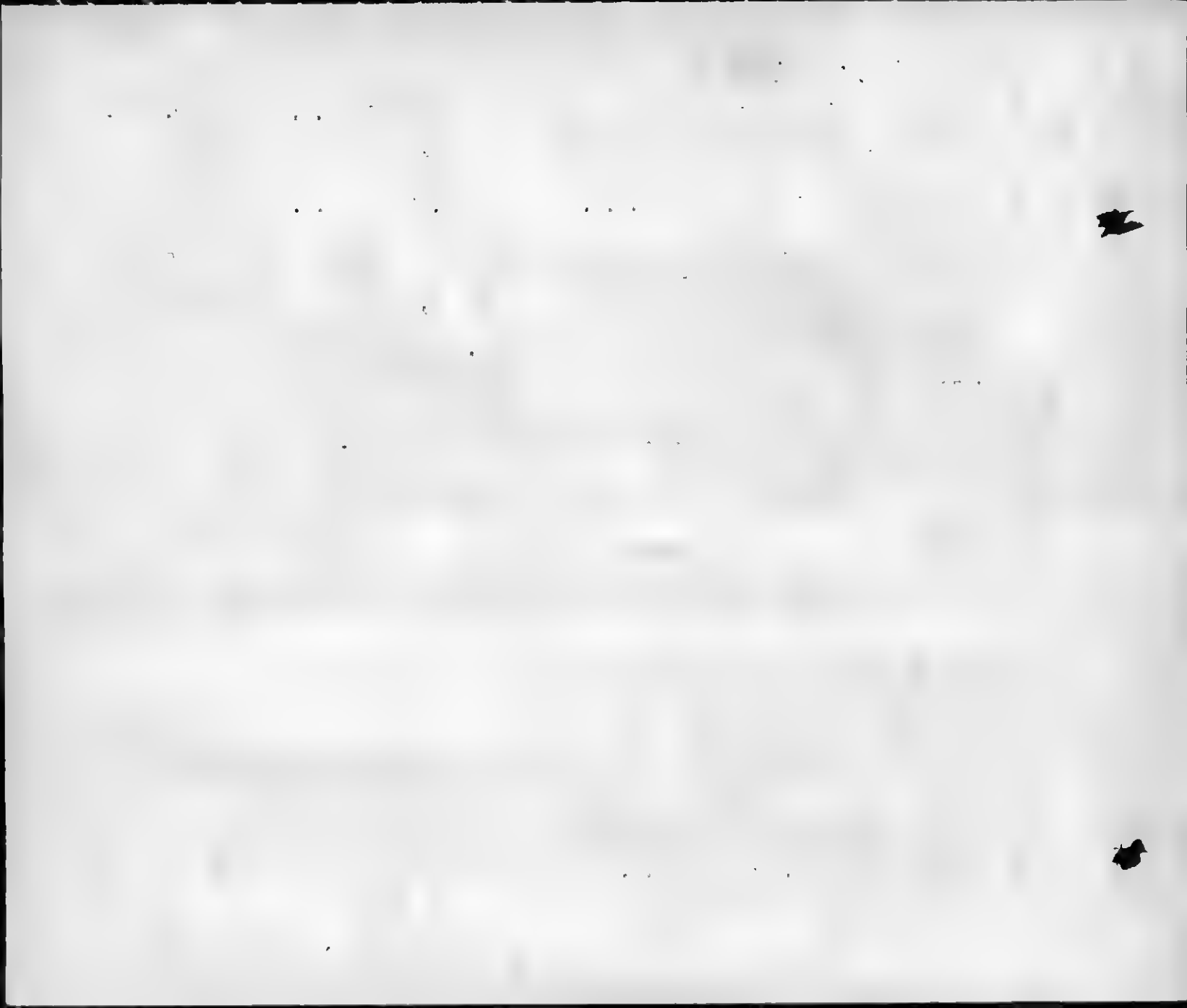
07193

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <del>MARYLAND</del> D.C. b. COUNTY <del>PRINCE GEORGES</del>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenilworth</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Avenue alongside B &amp; O.R.R.</b>		d. STREET ADDRESS <b>422 C.Street, N.E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Harrison Conley</b>		4. DATE OF DEATH Month Day Year <b>June 26 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N. Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Walls</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Conley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-05-9715</b>	
17. INFORMANT <b>William conley, Jr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exposure to heat</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>June 26, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/29/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Harmony Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Jefferson Hgts., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hoffman Funeral Home 909-688</b>		24a. REC'D BY REGISTRAR <b>June 30 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





7213

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>10 Hrs,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. STREET ADDRESS <b>7/College Park Maryland</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carroll E. Cox</b>				4. DATE OF DEATH Month Day Year <b>June 24 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>-12/19/11</b>	
9. AGE (In years lost birthday) yrs <b>48</b>		10. AGE (In years lost birthday) yrs <b>48</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Professor Botany University of Md</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>University of Md</b>			
13. FATHER'S NAME <b>Isaac Cox</b>				14. MOTHER'S MAIDEN NAME <b>Amy Eastburn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mrs Elizabeth Cox College Park, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic bronchogenic carcinoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ b. _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>April 1, 1960</b> to <b>June 24, 1960</b> that I last saw the deceased alive on <b>June 24, 1960</b> and that death occurred at <b>6:20pm</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harry N. Carlton</b> M.D.				ADDRESS (Street, city or town, state) <b>940-25th St N.W. Wash DC 6-2560</b>			
PHYSICIAN'S NAME (Type) <b>HARRY N. CARLTON, MD</b>				DATE SIGNED <b>Washington D.C.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>June 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Longwood Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Kenneth Square Pennsylvania</b>				22e. (State) _____		22f. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07195  
Reg. Dist. No.

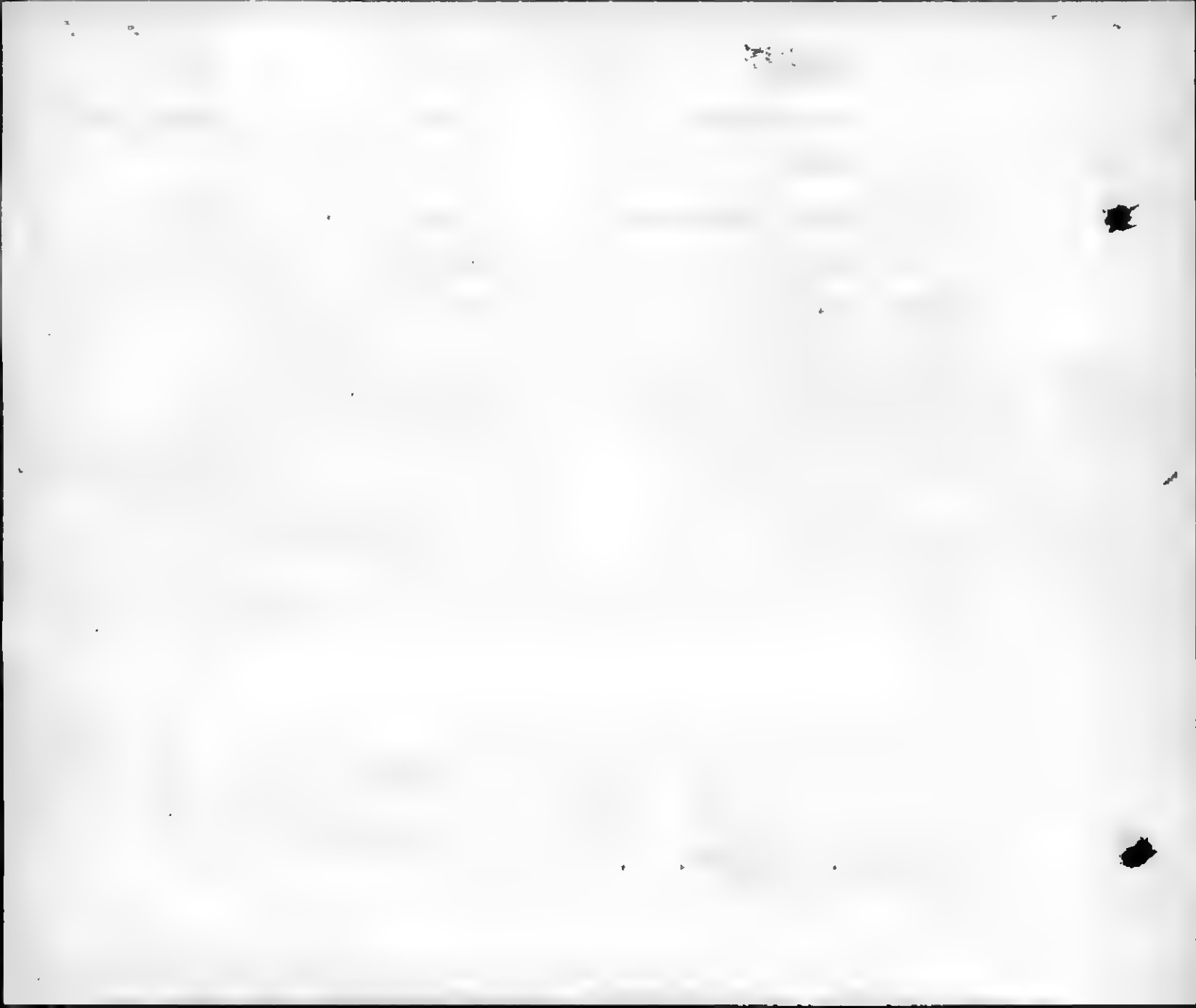
7214

Item 9 Film 6200 7-5-60 et

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisey</b> First <b>L.</b> Middle <b>Cressman</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 11, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home.</b>	
13. FATHER'S NAME <b>Henry Williams</b>		14. MOTHER'S MAIDEN NAME <b>Allice Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma Rt Colon</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1940</b> to <b>June 24, 1960</b> and that I lost the deceased alive on <b>June 24, 1960</b> , and that death occurred at <b>4345 Spout</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin</b> M.D.		ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Brainin WM. MD.</b>		DATE SIGNED <b>6/24/60</b>	
22a. BURIAL, CREMATION, or MONUMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. W. W. S. C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7213

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Culbertson</b>		4. DATE OF DEATH <b>13 June 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 June 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Culbertson</b>		14. MOTHER'S MAIDEN NAME <b>Marianne Peschel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>neonatal asphyxia</b> DUE TO <b>Hydrocephalus</b> (b) <b>Permaternity</b> DUE TO <b>Permaternity</b> (c) <b>Permaternity</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>Indet.</b> <b>2 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral clubbed feet, webbed fingers</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>o m.</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 13</b> , 1960, to <b>June 13</b> , 1960, that I last saw the deceased alive on <b>June 13</b> , 1960, and that death occurred at <b>10 PM</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry W. Penn, Jr.</b>		ADDRESS (Street, city or town, state) <b>West Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Barry Rosenberg</b>		DATE SIGNED <b>6/17/60</b>	
22a. BURIAL, CREMATION, OR OTHER REMOVAL (Specify) <b>Operation</b>		22b. DATE THEREOF <b>6/17/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077-22-18V2

23

15



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. **FUNERAL DIRECTOR** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 25, PRINCE GEORGES D.C.</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USAF HOSP ANDREWS</b>		d. STREET ADDRESS <b>6107 RITCHES ROAD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE WILLIAM CULLEMBER</b>		4. DATE OF DEATH Month Day Year <b>JUNE 14 19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 JULY 1915</b>
9. AGE (in years last birthday) <b>44 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, CHALRPT.</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>ALVIN OWEN CULLEMBER</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE I SIMMONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-18-6041</b>	
17. INFORMANT <b>GEORGE W CULLEMBER JR</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE AND SHOCK DUE TO SHOTGUN WOUND TO HEAD</b> DOA 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>DOA</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SELF INFLICTED WOUND</b>	
20c. TIME OF INJURY Month, Day, Year <b>Hour 1030 a. m. 6/14 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) (County) (State) <b>FORRESTVILLE PRINCE GEORGES MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JOHN T MALONEY MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 6-18-60</b>		22b. DATE THEREOF <b>6-18-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ALL HALLOW SCHAPPEL</b>		22d. LOCATION (City, town, or county) (State) <b>INDIANVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard J. Harding</b>		ADDRESS <b>Indiantown, Md</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	





7216

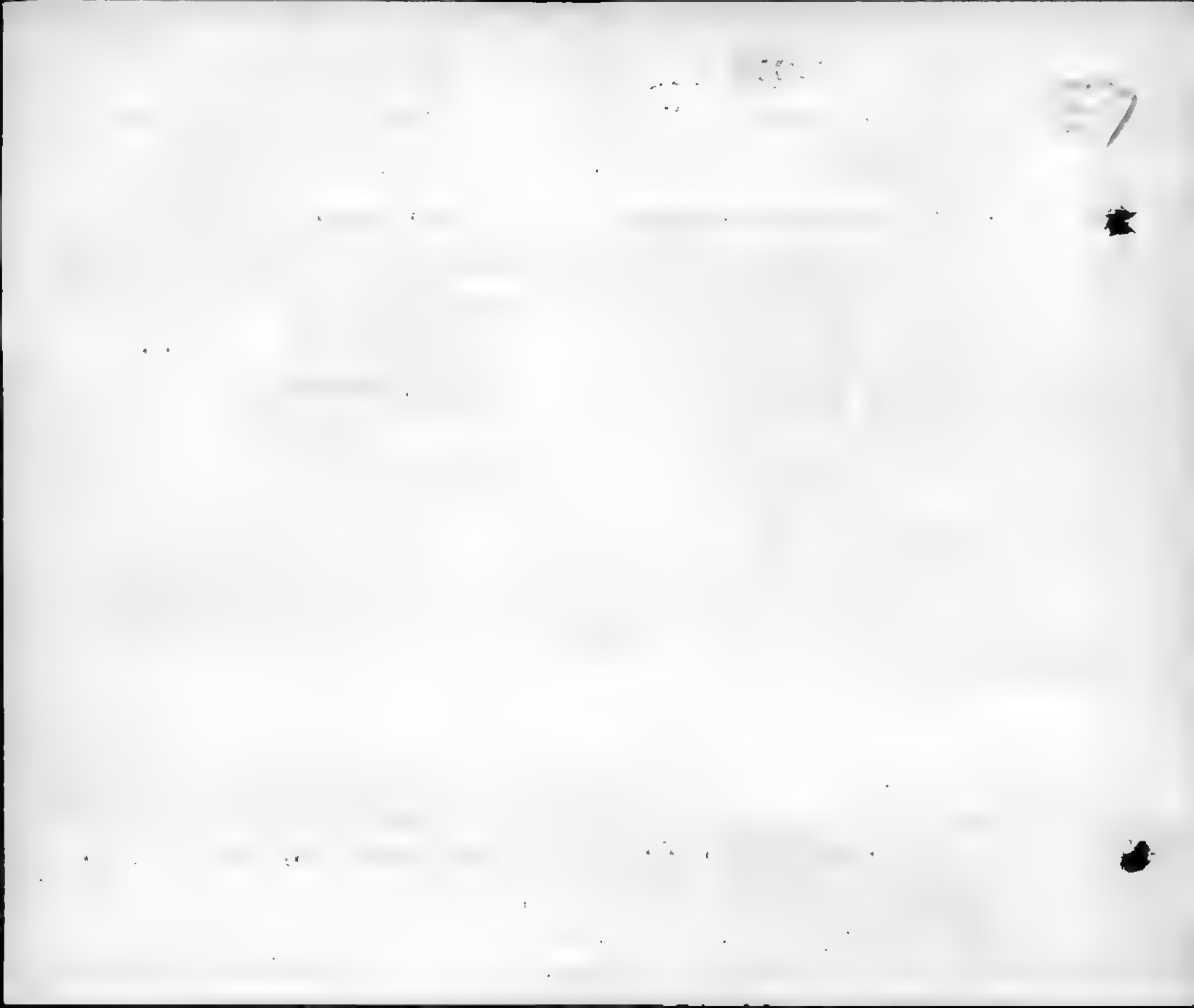
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy DeAngelis</b>		4. DATE OF DEATH <b>June 4 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ferdinand N De Angelis</b>		14. MOTHER'S MAIDEN NAME <b>Klar N Haberstock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Atelctan</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Preventative</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 4 1960</b> to <b>June 4 1960</b> that I last saw the deceased alive on <b>June 4 1960</b> and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John Perkins, M.D.</b>		DATE SIGNED <b>June 4 1960</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/17/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cheverly, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 22 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7277

## CERTIFICATE OF DEATH

Reg. Dist. No.

07200

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE</u>		c. LENGTH OF STAY IN 1b <u>8 HRS 30 MIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>USAF HOSPITAL ANDREWS</u>		e. STREET ADDRESS <u>5544 MAXWELL DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>(N/A)</u> Last <u>DE BLASI</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 JUNE 1960</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		10. IF UNDER 1 YEAR Months Days Hours Mins. <u>8</u> <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH S DE BLASI</u>		14. MOTHER'S MAIDEN NAME <u>HELEN McCUE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT <u>FATHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Respiratory distress syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature birth</u> DUE TO (c) <u>Premature birth</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>8 1/2 hrs</u> <u>8 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>13 June 1960</u> , to <u>13 June 1960</u> , that I last saw the deceased alive on <u>13 June 1960</u> , and that death occurred at <u>405</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAF HOSPITAL ANDREWS</u> <u>13 JUNE 60</u>			
ACTUAL SIGNATURE <u>John A Moore</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN A MOORE, MAJ, USAF, MC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JUNE 16 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knecht</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7278

## CERTIFICATE OF DEATH

Reg. Dist. No.

07201

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Hts.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2901 KENNEDY XXXX Fairlawn St.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Hillcrest Hts.</b>			
f. STREET ADDRESS <b>2110 Keating St.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Valeir</b> Middle <b>W. Gladys</b> Last <b>DONALDSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 8, 1898</b>	
9. AGE (In years lost birthday) <b>61</b> yrs		IF UNDER 1 YEAR Months <b>61</b>		IF UNDER 24 HRS. Days <b>61</b> Hours <b>61</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William F. Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Etta Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-36-1261</b>		17. INFORMANT <b>Eugene Donaldson (Son)</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/17, 1960</b> to <b>6/19, 1960</b> , that I last saw the deceased alive on <b>6/19, 1960</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2901 Fairlawn St SE Washington DC 20001</b> DATE SIGNED <b>6/19/60</b> ACTUAL SIGNATURE <b>David Wrenard</b> M.D. PHYSICIAN'S NAME (Type) <b>David Wrenard</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery Suitland, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b> ADDRESS <b>Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

1800

13

## CERTIFICATE OF DEATH

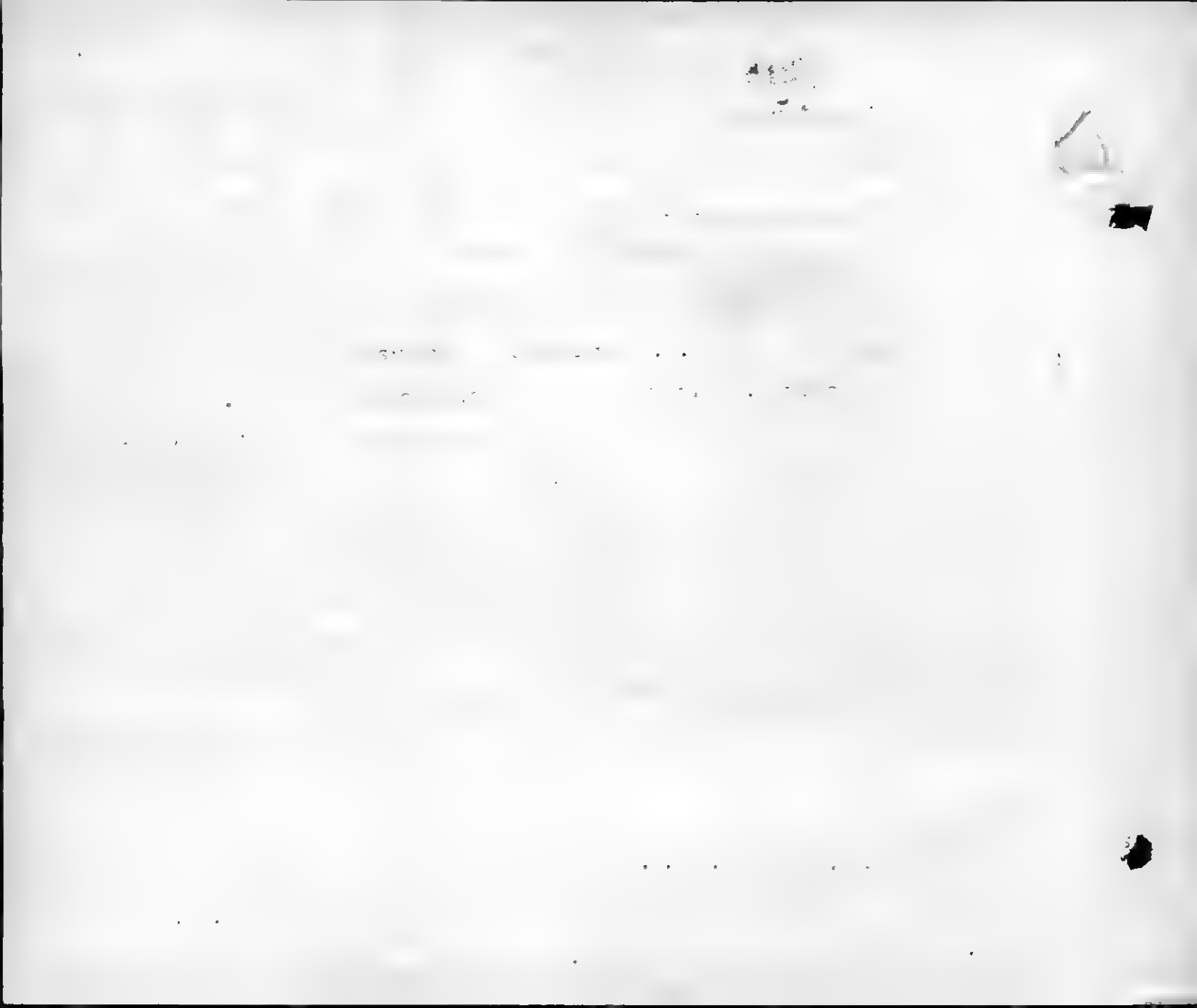
Reg. Dist. No.

07202

7217

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Harry Woodward Dorsey</b>		4. DATE OF DEATH Month Day Year <b>June 7 19 60</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 Nov 1874</b>
9 AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Harry W. Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Helen James</b>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO <b>Susie M Dorsey</b>	
17. ADDRESS <b>Hyattsville, Md.</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>coronary occlusion, on</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>arteriosclerosis heart disease</b> (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 h</b> <b>2 month</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>liver</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 20th, 1960</b> , to <b>June 7th, 1960</b> , that I last saw the deceased alive on <b>June 7th, 1960</b> , and that death occurred at <b>11 25 PM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Dr. Te Bergmann, M.D.</b>		M.D. <b>4314 2nd St. N.W. Washington D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Te Bergmann, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 10, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 10 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Carling S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No

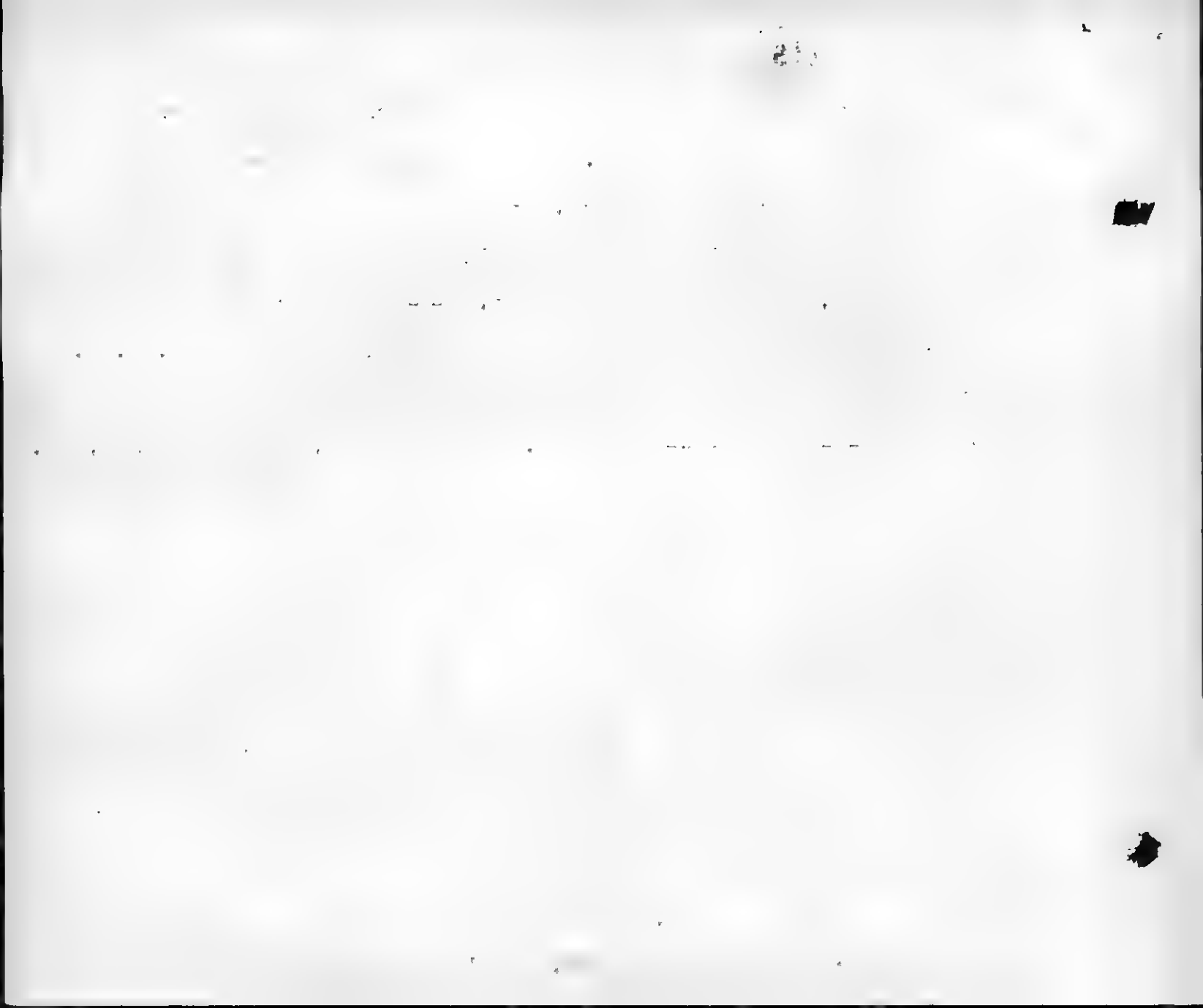
07203

7218

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Naylor Maryland</b>	
c. LENGTH OF STAY IN 1b <b>20 Da.</b>		d. STREET ADDRESS <b>--</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Alberta</b> Last <b>Downing</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Marx 4-6-81</b>
9. AGE (In years lost birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Naylor</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Martin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mrs. Archie Duvall, Upper Marlboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis Syms</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/17</b> , 19 <b>60</b> , to <b>6/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/6</b> , 19 <b>60</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman Donat Comeau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St</b> DATE SIGNED <b>6/6/60</b>	
PHYSICIAN'S NAME (Type) <b>Norman Donat Comeau</b>		<b>MT Rainier Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Croom Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

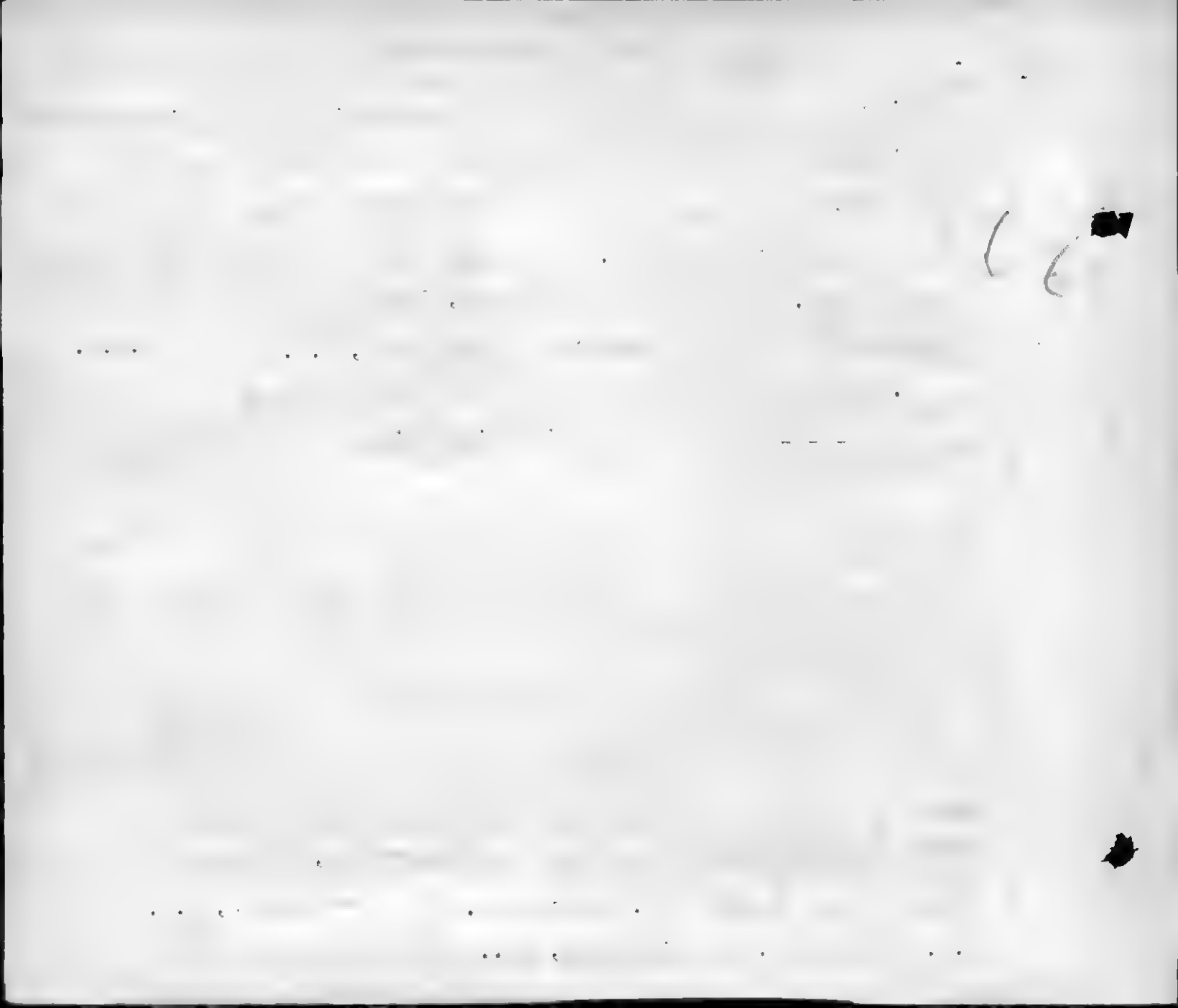
7263

## CERTIFICATE OF DEATH

Reg. Dist. No. 07204

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Riverdale</b>				c. LENGTH OF STAY IN 1b <b>66</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5804 Carters Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>C.</b> Last <b>DOWNS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 2, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>J. Molloy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Donoghue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>Miss Rita Chick</b>			
17. INFORMANT <b>same as #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Convulsion</b> DUE TO <b>Cerebral Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Heart Disease</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-1</b> , 19 <b>60</b> , to <b>6-26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-25</b> , 19 <b>60</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyattsville, Md 20786</b> DATE SIGNED <b>6-26-60</b> ACTUAL SIGNATURE <b>Aaron Dietz</b> M.D. <b>Hyattsville, Maryland</b> PHYSICIAN'S NAME (Type) <b>Aaron Dietz</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>				ADDRESS <b>Riverdale, Md..</b>		24a. REC'D BY REGISTRAR <b>JUN 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

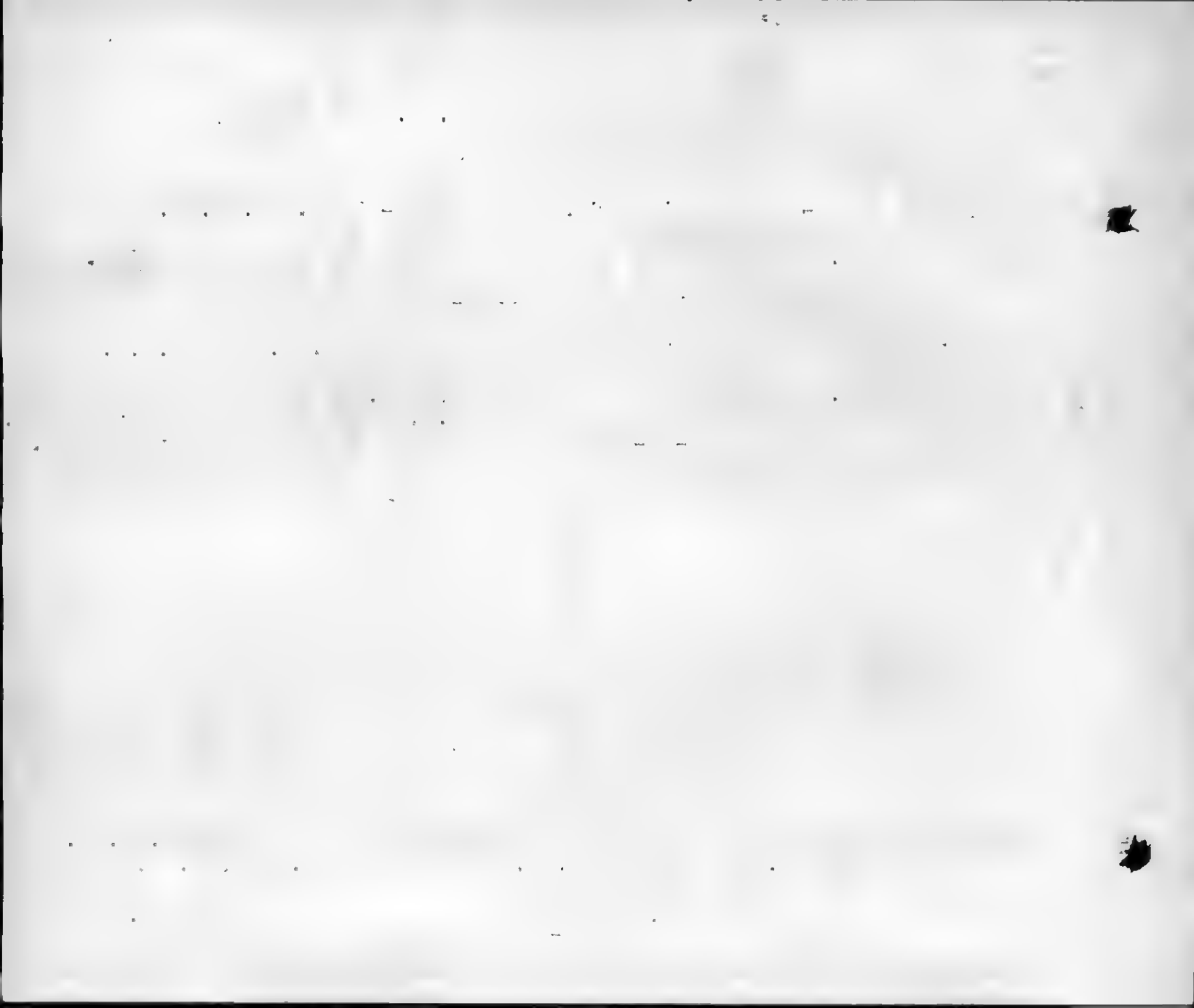
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7195

CERTIFICATE OF DEATH

Reg. Dist. No. 07205

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> c. LENGTH OF STAY IN 1b <b>WASHINGTON</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR- 4922 LaSALLE RD.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>4807 - 30th. ST. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Christian, First Aloysius Middle Eckloff Last also known as C. Louis Eckloff</b>		4. DATE OF DEATH Month Day Year <b>JUNE 26th, 19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-1875</b>
9. AGE (in years last birthday) <b>84</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian F. Eckloff</b>		14. MOTHER'S MAIDEN NAME <b>Margaret C. Caton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>577-22-3213A</b>	
17. INFORMANT <b>Joseph Sr. Bernadette</b>		Address <b>4922 LaSalle Rd. Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>49- X Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis - generalized.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 19 54</b> to <b>June 26, 19 60</b> that I last saw the deceased alive on <b>June 25, 19 60</b> and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Michael J. McInerney, M.D.</b>		DATE SIGNED <b>1150 Conn. Avenue - Washington, D. C.</b>	
PHYSICIAN'S NAME (Type) <b>MICHAEL J. MCINERNEY, M. D.</b>		<b>1150 CONN. AVE. N. W. WASH. D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-29-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Callins</b>		24a. REC'D BY REGISTRAR <b>Washington, DC</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>









# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07207

7264

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN Ib <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5618 Jamestown Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Charles</b> Middle <b>Francis</b> Last <b>Evans</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>11</b> , Year <b>19 60</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-26-12</b>
<b>9. AGE</b> (In years last birthday) <b>48</b> yrs.		<b>10. UNDER 1 YEAR</b> Months <b>4</b> Days <b>11</b>	<b>11. UNDER 24 HRS.</b> Hours <b>11</b> Min. <b>00</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Asst. Superintendent</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Post office</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Washington, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Thomas C. Evans</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lydia Vermillion</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.W.2</b>	
<b>17. INFORMANT</b> <b>Florence Evans; 9804 Dameron Drive Silver Springs, Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b> <b>DUE TO</b> <b>(b) Crushed chest</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b> <b>(c)</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile struck by another vehicle.</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>2:15 PM 6-11 19 60</b>		<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		<b>20f. (City or town) (County) (State)</b> <b>Beltsville Pr. Geo. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <b>John T. Maloney</b>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>DATE SIGNED</b> <b>June 11, 1960</b>	
<b>22a. BURIAL, CREMATION, REMOVAL, or other disposition</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6-14-1960</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Suitland Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Mattingly</b>		<b>ADDRESS</b> <b>131-11 1st St Wash DC</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 14 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Thomas</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse it by certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7196

## CERTIFICATE OF DEATH

Reg. Dis. No. 07208

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2215 University Blvd. Apt 103</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Hyattsville</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>SPENCER</u> Last <u>FAGAN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1885</u>
9. AGE (In years lost birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired LINESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pop. c.</u>	11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>
13. FATHER'S NAME <u>William Fagan</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hamilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-07-6054</u>	
17. INFORMANT <u>Wm. H. Easton</u>		Address <u>Wash. D.C. 914 R Ave SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4-20-60</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>60</u> , to <u>6/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>60</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hugh W. Irby</u>		ADDRESS (Street, city or town, state) <u>7105 - RIGGS, RD. HYATTSVILLE, MD.</u>	
DATE SIGNED <u>  </u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/20/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Co</u>
22d. LOCATION (City, town, or county) (State) <u>WASHINGTON DC</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>	
ADDRESS <u>1400 Chapin St. Wash. D.C. NW</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>
DATE <u>JUN 20 '60</u>		DATE <u>  </u>	

55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G264 6-10-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

07209

7279

1. PLACE OF DEATH a. COUNTY <i>for Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland Md</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suitland Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMP SPRINGS</i>	
f. STREET ADDRESS <i>17206 Cadledge Rd SE</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>HATTIE F FEWELL</i>		4. DATE OF DEATH Month Day Year <i>6 2 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1878 Oct 18-1878</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Holliday</i>		14. MOTHER'S MAIDEN NAME <i>Mary Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>555-55-5555</i>	
17. INFORMANT <i>MRS MORSEY E LUTTRELL #2</i>		Address <i>Suitland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac - vascular Renal Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arterio-sclerosis</i> DUE TO (c) <i>Senility</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple cerebral vessel accidents</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from <i>1945</i> , 19, to <i>June 2, 1960</i> , that I last saw the deceased alive on <i>June 1, 1960</i> , and that death occurred at <i>3:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3550 Manna Ave S.E. Wash D.C. 6-2-60</i> DATE SIGNED <i>Bernard Katzen</i>			
ACTUAL SIGNATURE <i>Bernard Katzen</i>		M.D. <i>Bernard Katzen M.D.</i>	
PHYSICIAN'S NAME (Type) <i>BERNARD KATZEN</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>June 4-60</i>	<i>Cedar Hill</i>	<i>Suitland Md</i>
23. FURNERAL DIRECTOR'S SIGNATURE <i>Sam Bros 1661-4th Hope Rd</i>		24a. REC'D BY REGISTRAR <i>DATE JUN 6 '60</i>	
ADDRESS <i>Sam Bros 1661-4th Hope Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7280

Items 9, 8 Film 62c6 7-8-61 et

CERTIFICATE OF DEATH

07210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Carrollton Md		c. LENGTH OF STAY IN 1b 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton Md.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6008 84th avenue	
d. STREET ADDRESS 6008 84th avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Winslow Flournoy		4. DATE OF DEATH Month Day Year June 5, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6, 1873
9. AGE (In years last birthday) 87 86rs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Copley Winslow		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Josiah A Flournoy		Address Carrollton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary Right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 19 to 6/5 1960 that I last saw the deceased alive on 6/4 1960, and that death occurred at 7:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE James Kutz		DATE SIGNED 6/5/60	
PHYSICIAN'S NAME (Type) James Kutz		ADDRESS (Street, city or town, state) RFD Bowie Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Valley		22d. LOCATION (City, town, or county) (State) Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07211**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**7220**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>6 Maple Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Allen</b> Middle <b>Mitchell</b> Last <b>Foster</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-22</b>		9. AGE (in years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James G. Foster</b>				14. MOTHER'S MAIDEN NAME <b>Ella Mae Campbell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2 577164392</b>		17. INFORMANT Address <b>Agnes M. Foster; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO <b>Gunshot wound of chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by another person.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:45 p m June 25 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Bowie Prince Georges Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>		EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 29, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Fyattsville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>C. S. K...</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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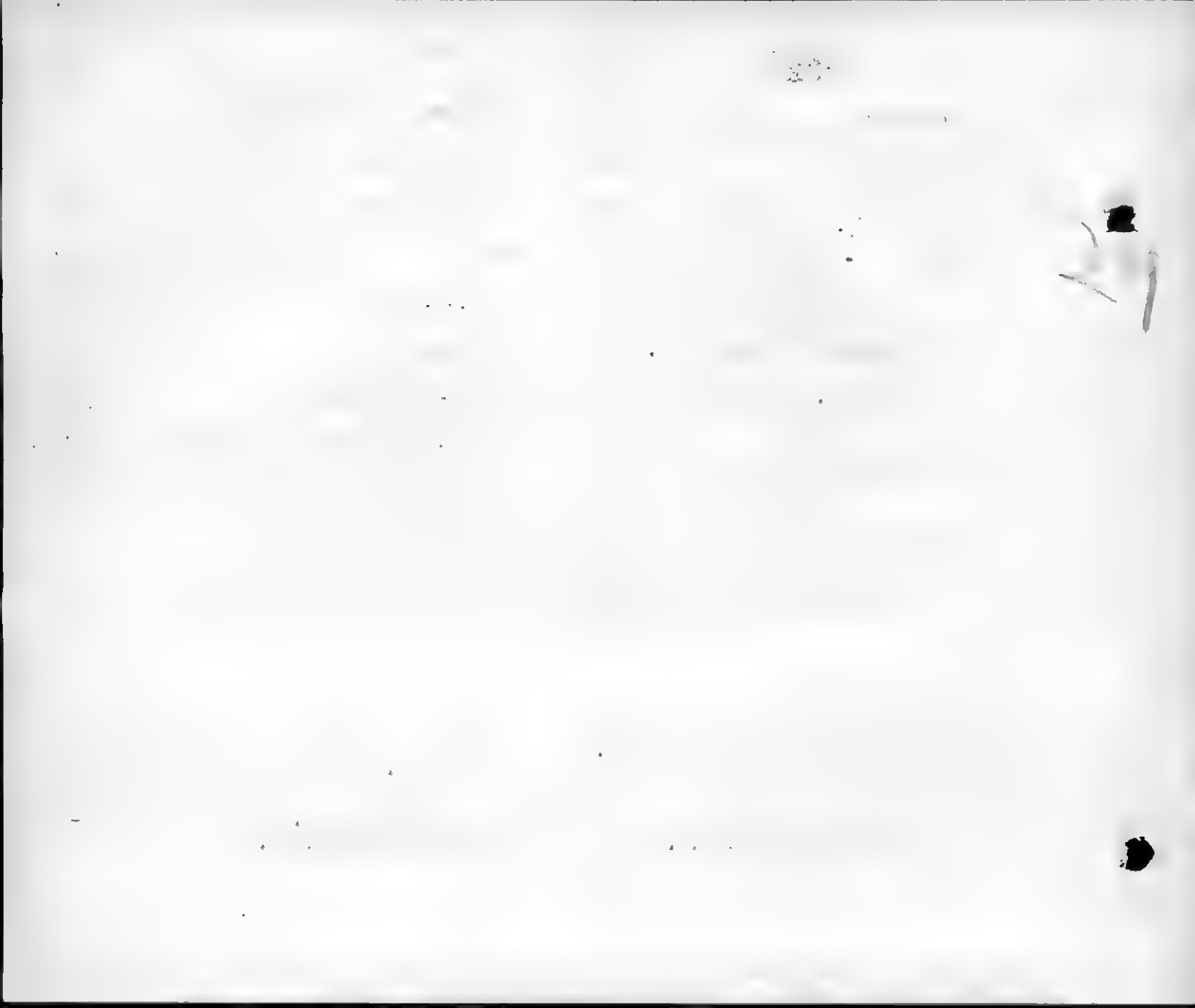
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>15 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>511 70th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Willis A Getchell</b>			4. DATE OF DEATH Month Day Year <b>June 10 1960</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1930</b>		9. AGE (In years lost birthday) <b>29</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographer-USN-USGov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Willis A. Getchell</b>			14. MOTHER'S MAIDEN NAME <b>Lana-May Springer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>718-01-0378</b>		INFORMANT Address <b>Willis A. Getchell, #5 Park St Newport, Maine</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO _____ (c) DUE TO _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 1, 1959</b> to <b>June 10, 1960</b> , that I last saw the deceased alive on <b>June 10, 1960</b> , and that death occurred at <b>3:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6124 Central Ave. Capitol Heights, Md.</b> DATE SIGNED <b>6-10-60</b>							
ACTUAL SIGNATURE <b>Dr Peter Duus</b>		M.D.		6124 Central Ave. Capitol Heights, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Newport, Maine</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan Inc</b>		ADDRESS <b>317 Pa Ave SE</b>		24a. REC'D BY REGISTRAR <b>JUN 13 '60</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

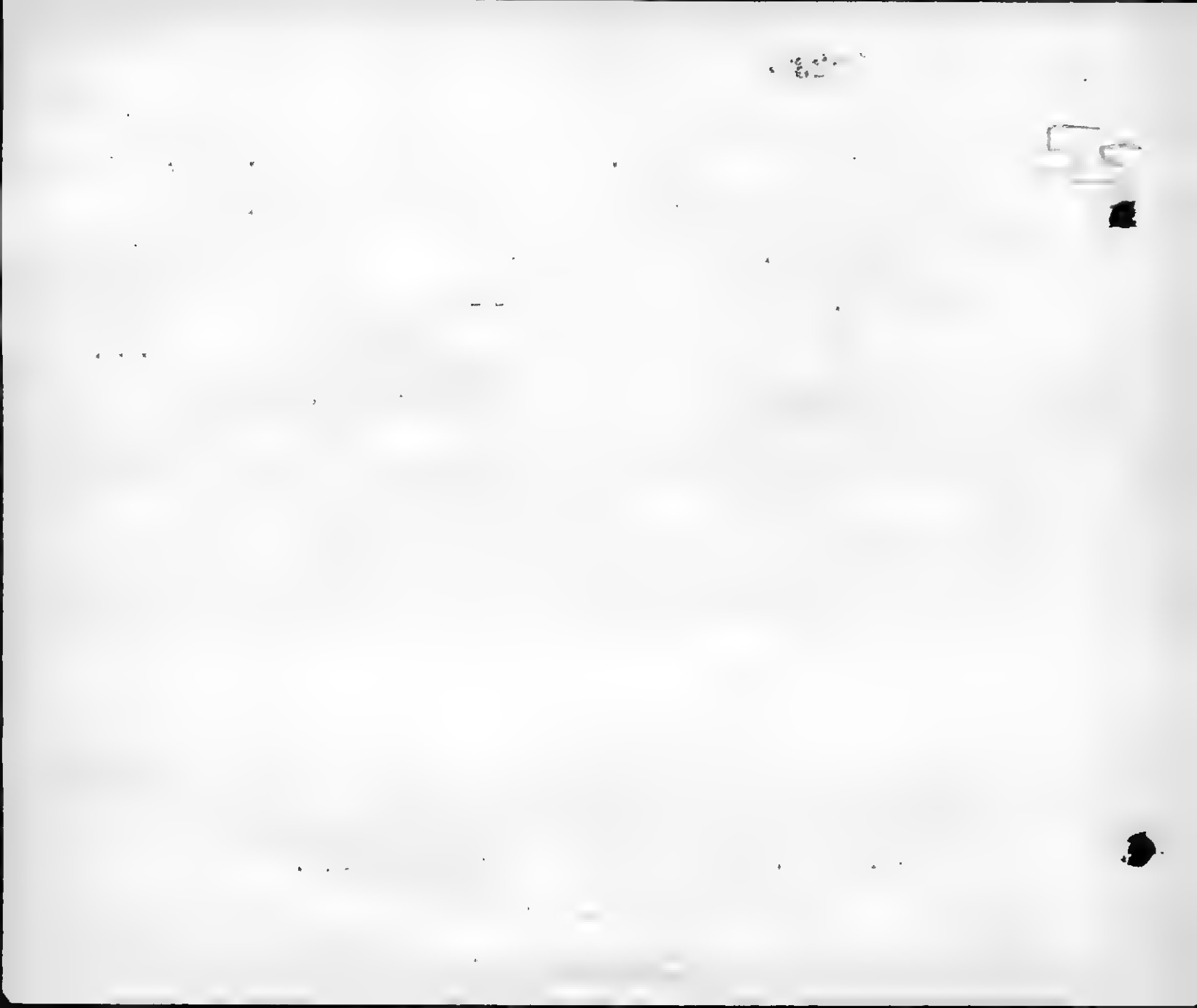
7222

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>7300 18 th Ave Apt. 16 ,Hyattsville</b>	
f. STREET ADDRESS <b>7300 18 th Ave Apt. 16</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy B. Gilmore</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 60</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-17-60</b>
9. AGE (in years last birthday) <b>1</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ned Gilmore</b>		14. MOTHER'S MAIDEN NAME <b>Frances Lillian Rawlings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Same</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>762.5</b> IMMEDIATE CAUSE (a) <b>atelectasis</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c) <b>Due to</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-17-60</b> , 19 <b>60</b> , to <b>6-18</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-18</b> , 19 <b>60</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton Street</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>		DATE SIGNED <b>H yattsville, Md.</b>	
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b DATE THEREOF <b>June 24, 1960</b>	
22c NAME OF CEMETERY OR CREMATORY <b>Prince George's General</b>		22d LOCATION (City, town, or county) (State) <b>Cheverly, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a REC'D BY REGISTRAR <b>DATE JUN 29 '60</b>	
24b REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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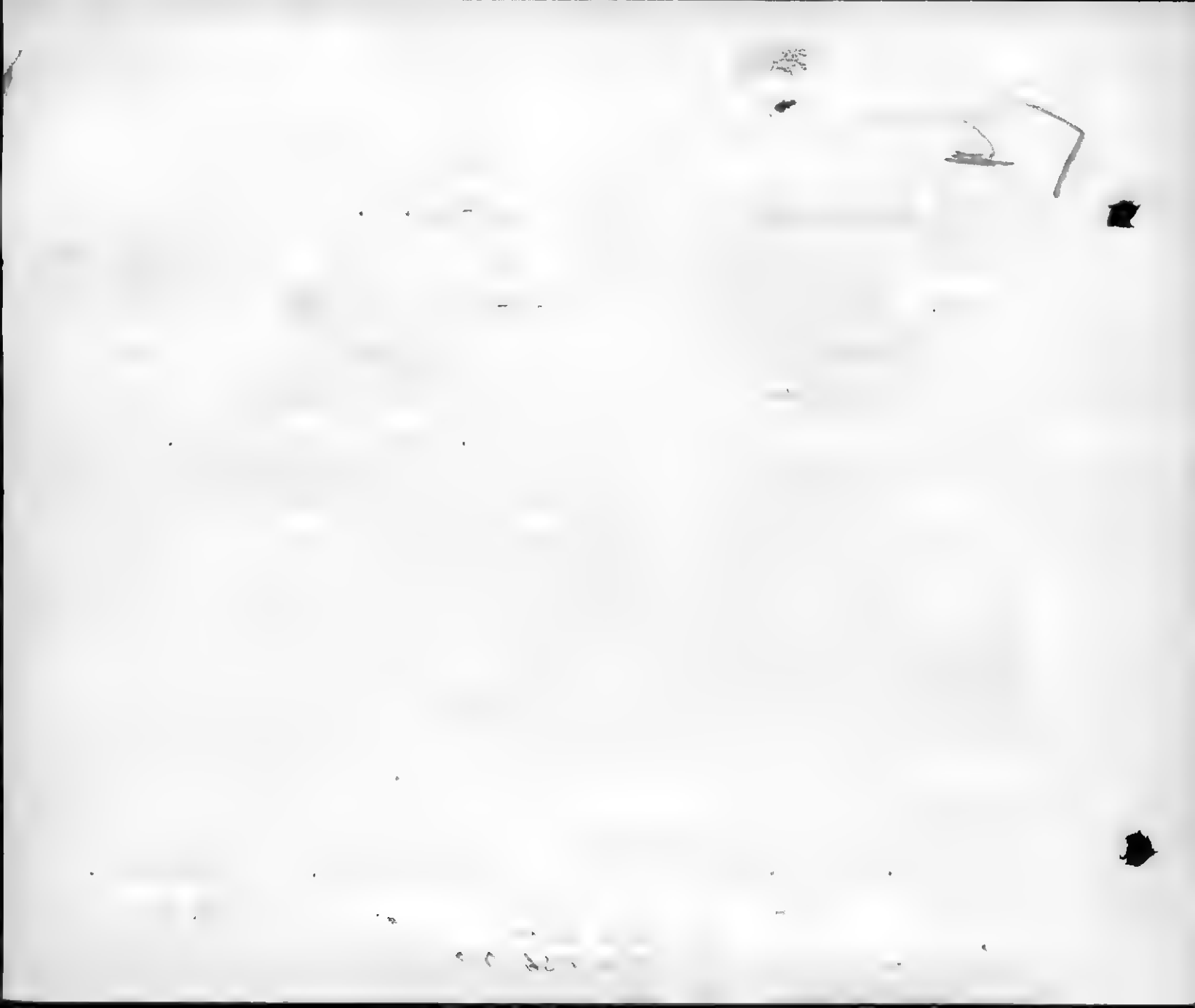
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## CERTIFICATE OF DEATH

Reg. Dist. No. **07215****7224**

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>		d. STREET ADDRESS <b>303-61st Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eda</b>		First <b>Eda</b>		Middle <b>V</b>		Last <b>Greer</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>2</b>		Year <b>1960</b>			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-19-86</b>		9 AGE (In years last birthday) <b>73</b> yrs		F UNDER 1 YEAR Months <b>73</b>		D UNDER 24 HRS Days <b>73</b>		H UNDER 24 HRS Hours <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Wetsel</b>				14. MOTHER'S MAIDEN NAME <b>Gaesche Behrends</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO				INFORMANT <b>Raymond A. Greer 303 61st Ave Capt. Hghts Md</b>				Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral arterio-sclerosis</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary heart disease</b> 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept</b> , 1952, to <b>6-1-</b> , 1960, that I last saw the deceased alive on <b>June 2</b> , 1960, and that death occurred on <b>2:30A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6124 Central Ave. Capitol Heights Md</b> DATE SIGNED <b>June 2 1960</b> ACTUAL SIGNATURE <b>Peter Brann</b> M.D. <b>6124- Central Ave</b> PHYSICIAN'S NAME (Type) <b>Dr. Brann-Dr. Duns</b> <b>6124 Central Ave. Capitol Heights Md.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-6-60</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Washington, DC</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>SIMMONS BROS. RD. SE WASH. D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 6 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thrash</b>							



may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

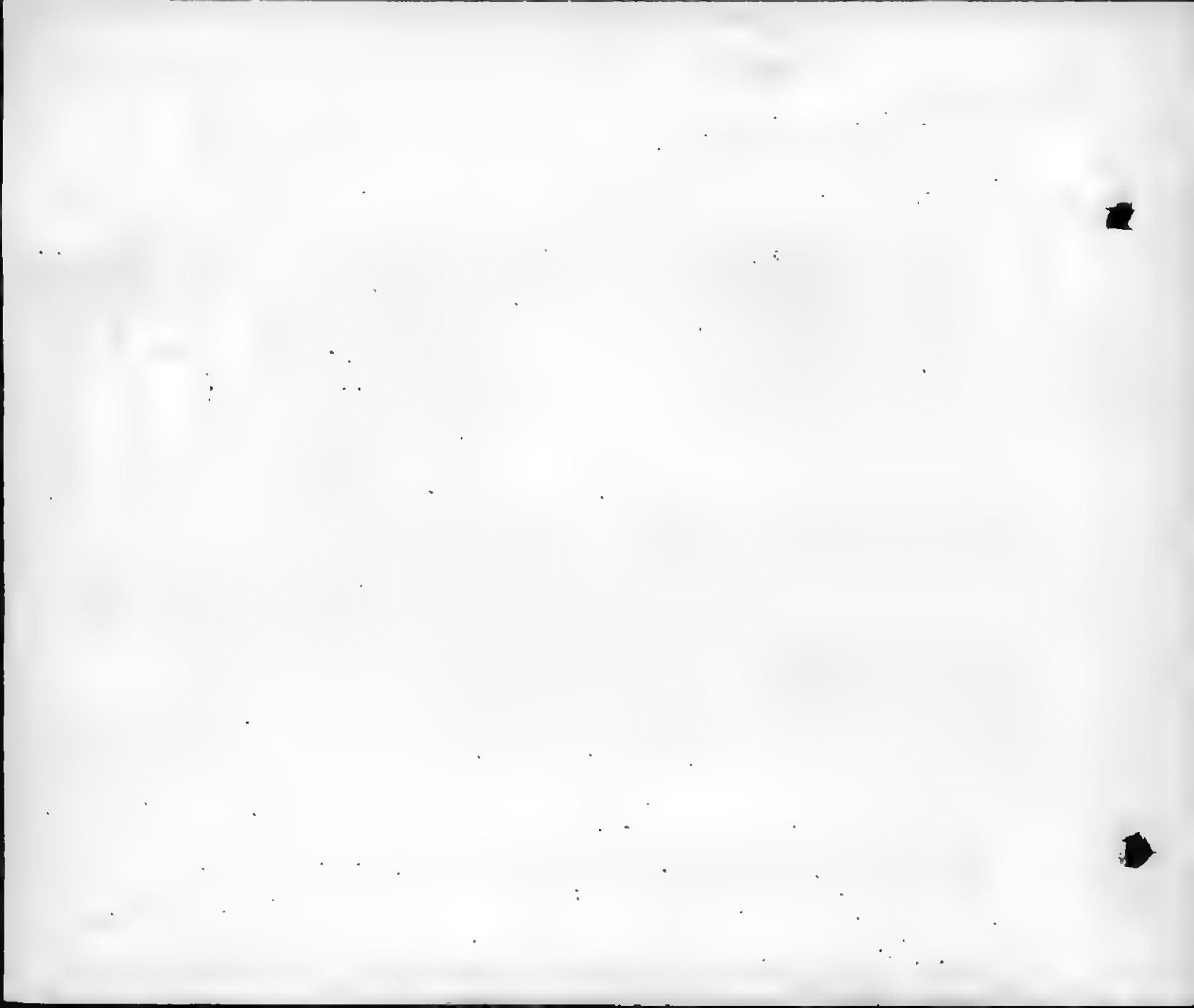
See: Birth Cert. et

## CERTIFICATE OF DEATH

Reg. Dist. 07216

7281

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>1.3 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>So. Md. Hosp. Center</u>		d. STREET ADDRESS <u>Waldorf</u> Rt. # <u>5</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>HAGENS</u> Middle <u>HAGENS</u> Last <u>HAGENS</u>		4. DATE OF DEATH <u>6-19-60</u> Month <u>6</u> - Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-60</u>
9. AGE (In years lost birthday) yrs. <u>15</u>		10. IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HAGENS</u>		14. MOTHER'S MAIDEN NAME <u>MARY HEARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>MOTHER - WALDORF, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>NEONATAL - PREMATURE</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1.3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-19</u> , 19 <u>60</u> , to <u>6-19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>60</u> , and that death occurred at <u>5-1</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vivian Chang</u> M.D.		ADDRESS (Street, city or town, state) <u>So. Md. Hosp Center</u>	
PHYSICIAN'S NAME (Type) <u>Vivian Chang</u>		CLINTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-21-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf Md.</u>		24. REC'D BY REGISTRAR <u>ARTHUR S. KRAUS</u>	
ADDRESS <u>2084335XV2</u>		DATE <u>27'60</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

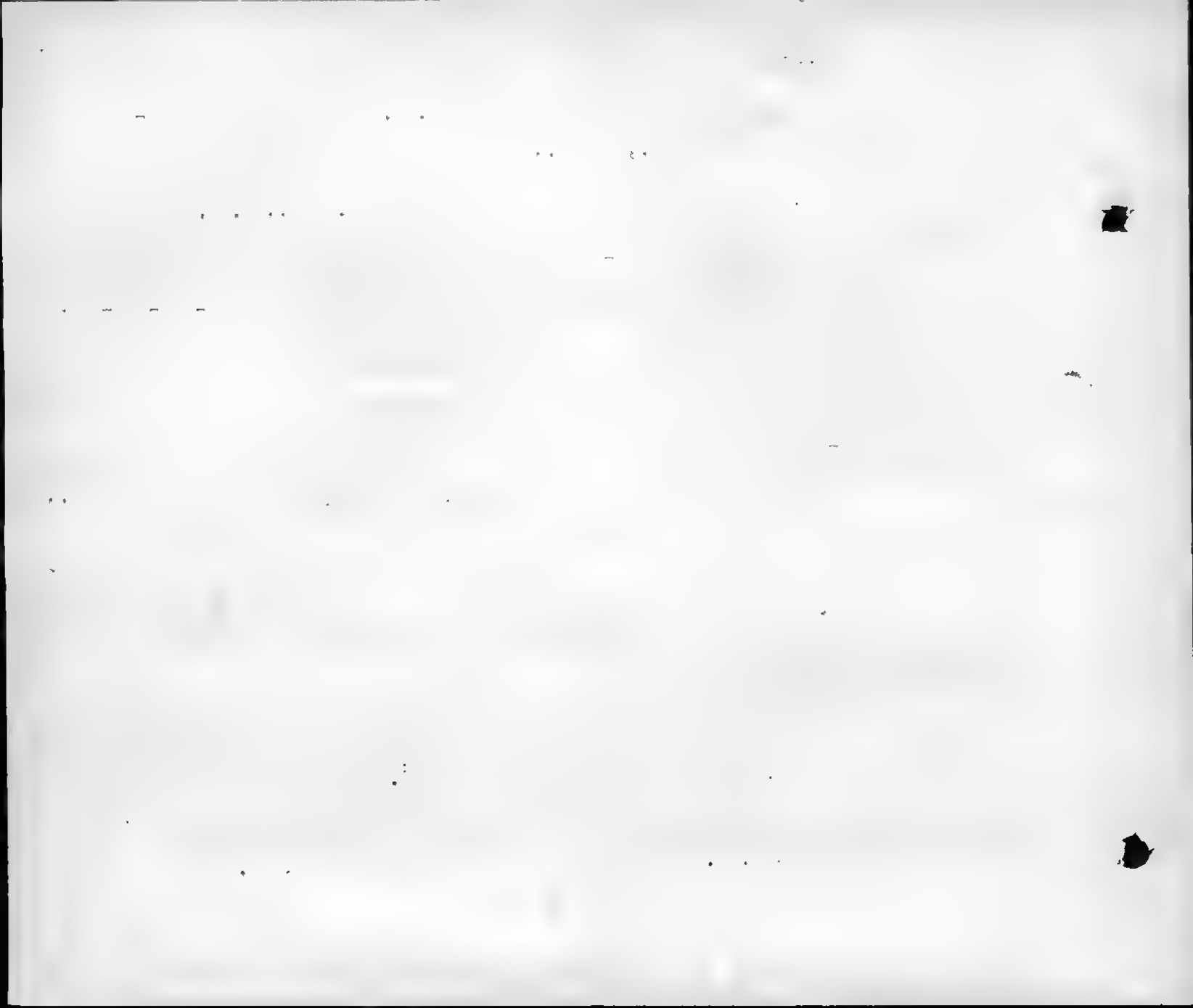
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7282

## CERTIFICATE OF DEATH

07217

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>2 yrs., 4 mos., &amp; 1 day</b>				d. STREET ADDRESS <b>515 Mass. Ave., N. W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>-</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>6</b> Day <b>8</b> Year <b>1960</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/88</b>		9 AGE (In years last birthday) <b>71</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marble worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11 BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>George Hall</b>				14. MOTHER'S MAIDEN NAME <b>Teresa McCoy</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown (lost)</b>		17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.,</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the prostate with metastases to the spine; generalized arteriosclerosis</b>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>2/7</b> <b>1958</b> to <b>6/8</b> <b>1960</b> that (I) (we) last saw the deceased alive on <b>6/8</b> <b>1960</b> and that death occurred at <b>12:05</b> <b>A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Moe Weiss</b>		M. D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>6/8/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/8/60</b>		23b. DATE THEREOF <b>6/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>D.C. Morgan</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thomas</b>				25a. REC'D BY REGISTRAR <b>JUN 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7283

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07218

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1000 Block 64th Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Thomas</b> Last <b>Harley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1920</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months <b>39</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Musicien</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Music</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas Harley</b>				14. MOTHER'S MAIDEN NAME <b>Alma Kelley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>John K. Harley; 1301 Taylor St. Wash., D.C.</b>			
17. INFORMANT <b>John K. Harley; 1301 Taylor St. Wash., D.C.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Air embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>I.V. Medication</b> DUE TO (c) <b>Undetermined</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/29/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>				ADDRESS <b>30 H Street, N.E. DC</b>			
24a. REC'D BY REGISTRAR <b>DATE JUL 1 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give item 1, 2, and 3 in the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18. Page 5 may be retained for your use. File pages 1 and 2 with the registrar for burial, cremation, or removal.



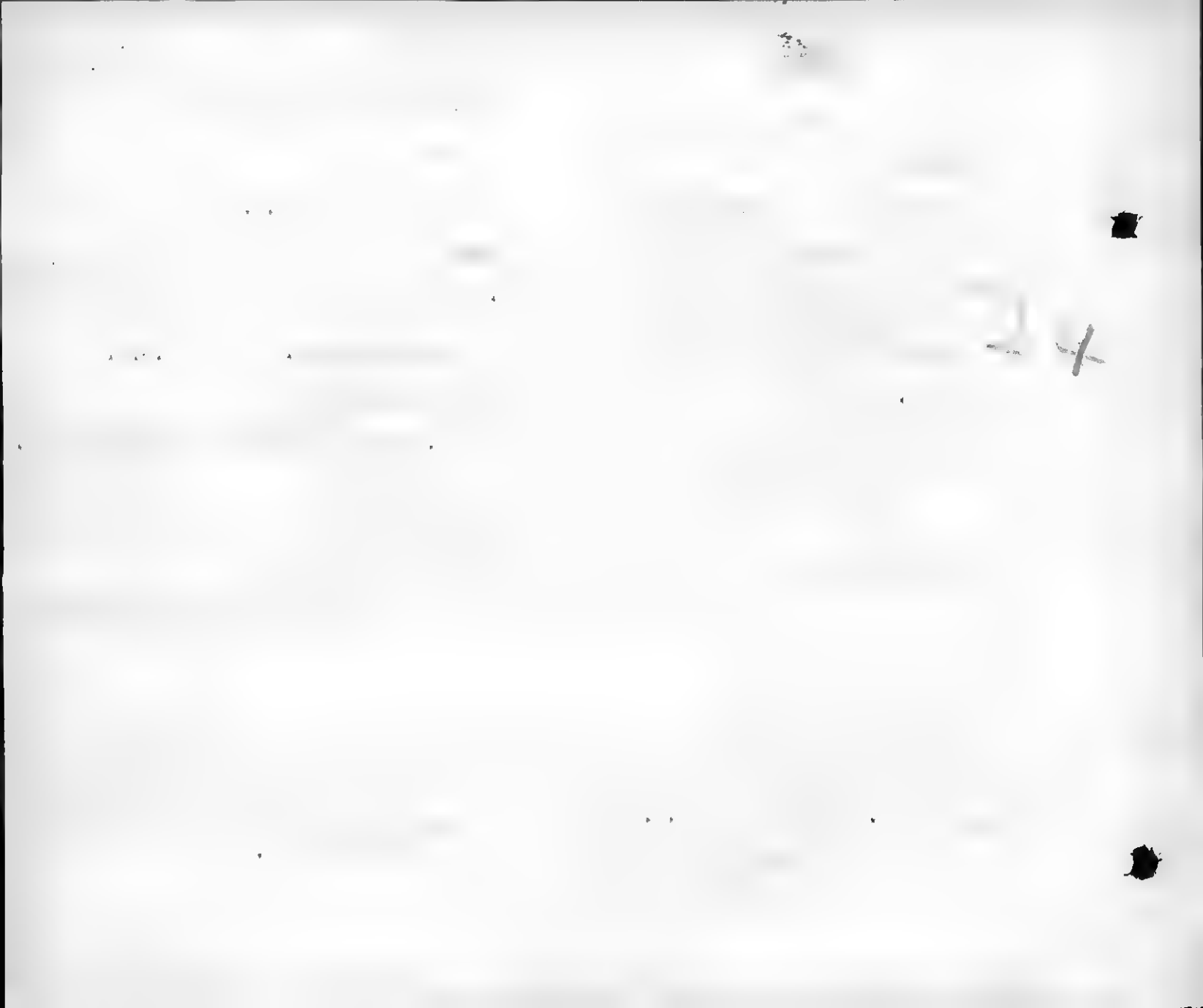


7223

## CERTIFICATE OF DEATH

Reg. Dist. No. 07219

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>24</b> <b>District Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Harman</b> Last <b>Harman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>25</b> Hours <b>19</b> Min. <b>60</b>	11. IF UNDER 24 HRS Months <b>71</b> Days <b>25</b> Hours <b>19</b> Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilksburg Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Ansler</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Vogler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Walter J. Harman</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease 2 yrs</b> DUE TO (c) <b>5 hrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 59</b> to <b>June 25 19 60</b> that I last saw the deceased alive on <b>June 25 19 60</b> and that death occurred at <b>1:25 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Dr. Norman Comeau M.D.</b>		ADDRESS (Street, city or town, state) <b>3509 Perry St Mt Rainier, Md.</b>	
DATE SIGNED <b>6/25/60</b>			
PHYSICIAN'S NAME (Type) <b>Norman Comeau</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 27, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	
ADDRESS <b>1661 Woodhurst Wash. 20, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

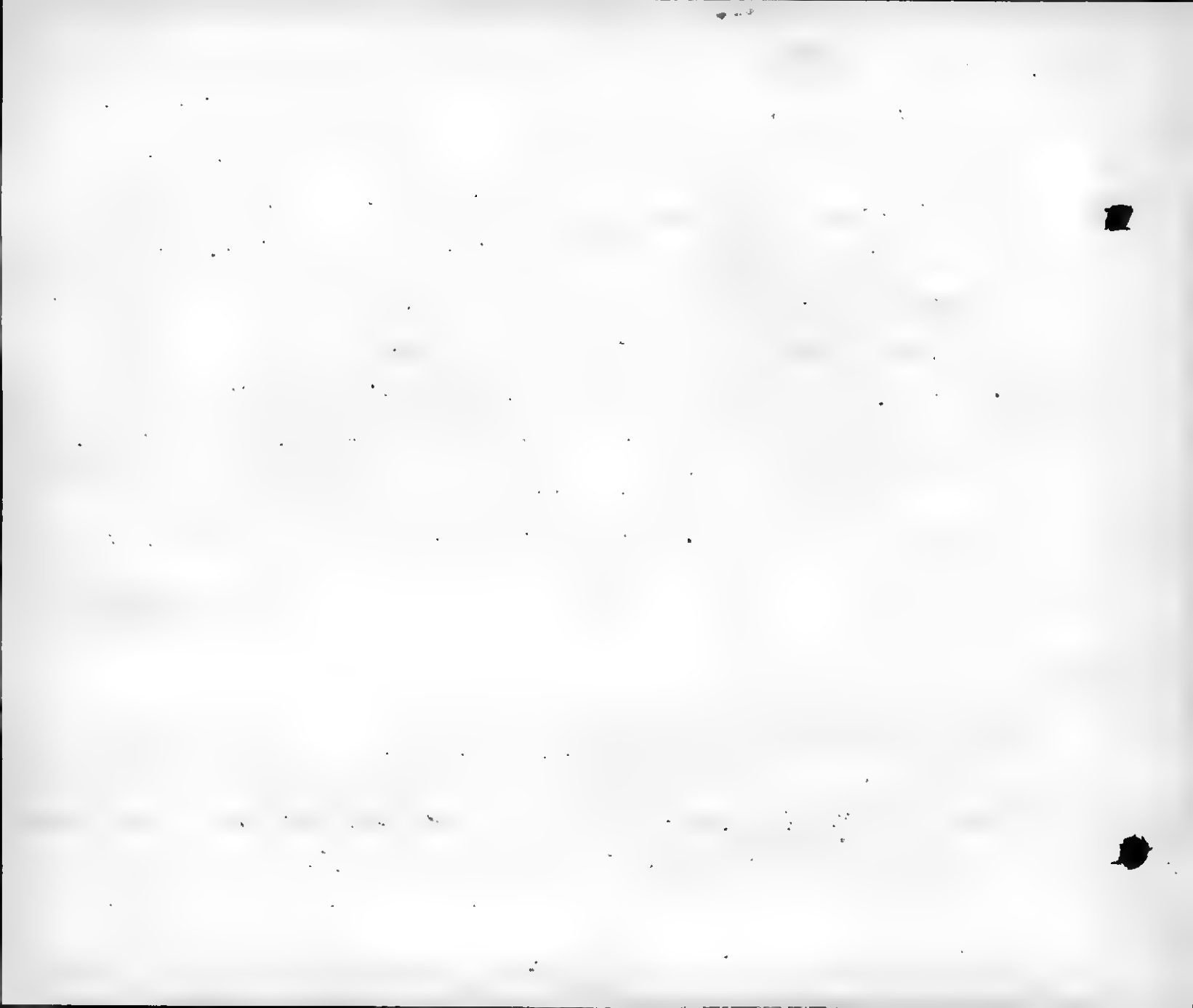
07220

7284

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 1b <i>4 hrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>So md Hospital Center</i>		e. STREET ADDRESS <i>7150 Temple Hill Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Katherine Ann</i> First Middle Last <i>HARRIS</i>		4. DATE OF DEATH Month <i>June</i> Day <i>29</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>CAU</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 29, 60</i>
9. AGE (In years last birthday) <i>4</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>18</i> Hrs. <i>18</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE - INFANT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Martin William Harris Jr</i>		14. MOTHER'S MAIDEN NAME <i>June Dolores Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Father</i>		Address <i>7150 Temple Hill Rd., Clinton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> <i>761.5</i> DUE TO <i>Early Rupture of Membranes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>24 hrs</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 29</i> , 19 <i>60</i> , to <i>June 29</i> , 19 <i>60</i> that I last saw the deceased alive on <i>June 29</i> , 19 <i>60</i> , and that death occurred at <i>9:10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gleason M.D.</i>		ADDRESS (Street, city or town, state) <i>5500 22nd Ave SE</i> DATE SIGNED <i>June 29, 60</i>	
PHYSICIAN'S NAME (Type) <i>SANTIAGO L. GARZA</i>		<i>Hillcrest Heights Md.</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>7/1/1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATL Cem</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS Co - 517-1105 SE.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>2084 22nd Ave</i>		DATE <i>JUL 1 '60</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07221

Item 14 Baltimore 7-19-60 et

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2817 Gainsville Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Leonard</b> Middle <b>Worth</b> Last <b>Harris</b>		<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>21</b> Year <b>1960</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov, 11, 1886</b>
<b>9. AGE</b> (n years last birthday) <b>73 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>73</b> Days <b>73</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laundryman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Laundry</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Richard B. Harris</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary (Surname unknown)</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-07-1768</b>	
<b>17. INFORMANT</b> <b>Harriet E. Harris; same address as # 2.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Toxemia and exhaustion</b>  <b>DUE TO</b>  <b>Septicemia</b>  <b>Fracture of right tibia and fibula</b> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>A pedestrian; struck by an automobile while crossing highway.</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>8.00</b> a. m. <b>6-15-</b> 1960		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b> <b>20f. (City or town)</b> <b>Bladensburg, Fr. Geo. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/&gt;, and find that death resulted from: Natural causes &lt;input type="/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i>		<b>DATE SIGNED</b> <b>June 21, 1960</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6/23/60</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Suitland Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>		<b>ADDRESS</b> <b>Hyattsville, Md.</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>JUN 24 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Howard</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7285

## CERTIFICATE OF DEATH

Reg. Dist. No.

07222

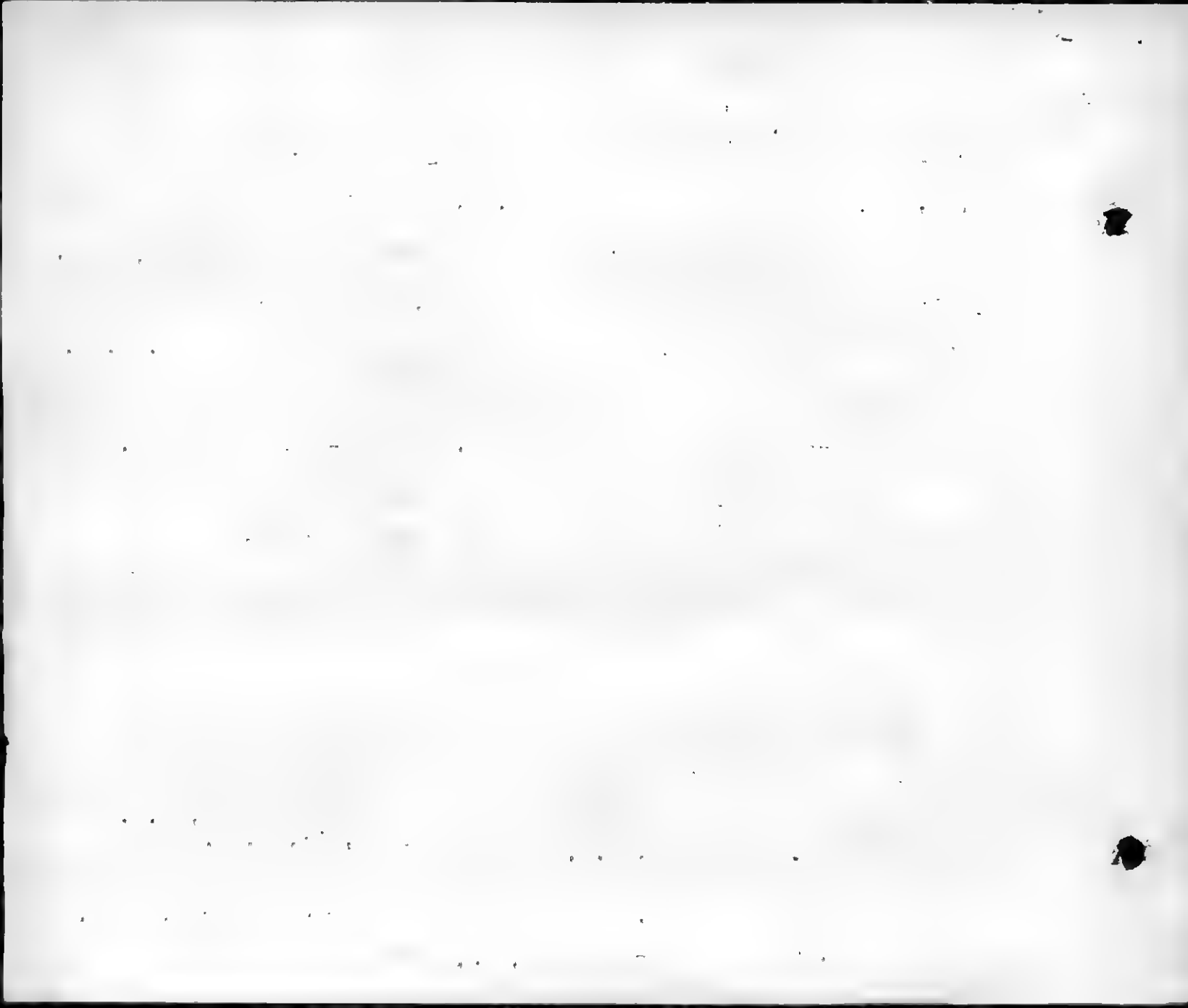
1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Box 1339		d. STREET ADDRESS Rt. 1, Box 1339	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Anna Hawkins		4. DATE OF DEATH Month Day Year June 9, 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Johnson		14. MOTHER'S MAIDEN NAME Susie Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address James A. Hawkins-Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cardiovascular, Renal Disease DUE TO (c) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Natural Causes 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs. Unknown Unknown	
21. I certify that I attended the deceased from Jan 1, 19 59 to June 9, 19 60 that I last saw the deceased alive on June 9, 19 60 and that death occurred at 7:15 P.M. from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) 5440 Silver Hill Road, S.E. 6/9/60: Washington, 28, D. C.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Paul C. Van Natta M.D.		DATE SIGNED 6/9/60	
PHYSICIAN'S NAME (Type) Paul C. Van Natta, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
DATE JUN 14 '60			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58





7286

## CERTIFICATE OF DEATH

Reg. Dist. No.

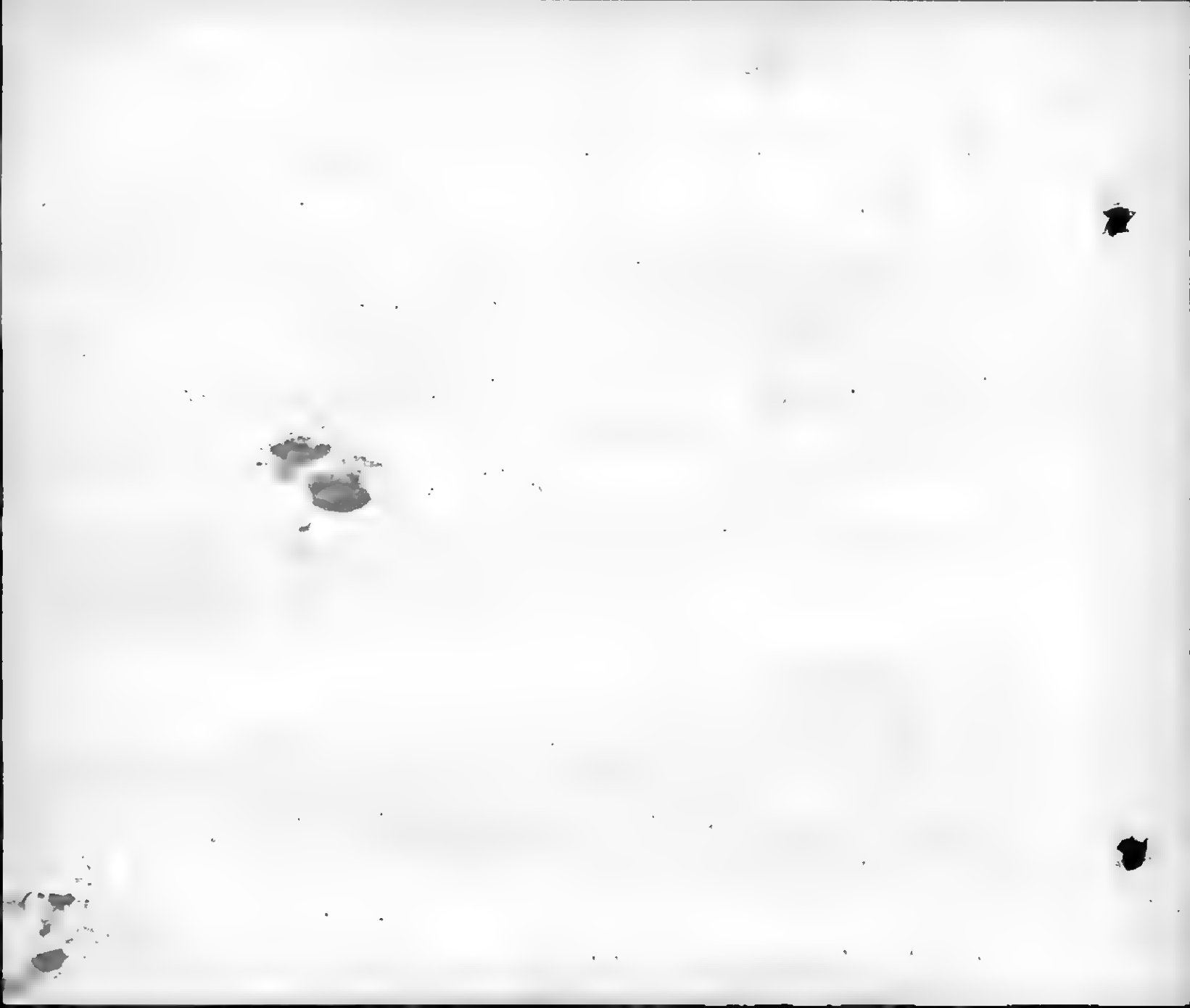
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>			
c. LENGTH OF STAY IN 1b <b>49 DAYS</b>				d. STREET ADDRESS <b>1504 SECOND ST., SW</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS, WASH 25 DC</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>L</b> Last <b>HICKS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 JULY 1933</b>	9. AGE (In years lost birthday) <b>26</b> yrs	IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	IF UNDER 24 HRS Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US AIR FORCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TEXAS</b>		11. BIRTHPLACE (State or foreign country) <b>UNITED STATES</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>LEON HICKS</b>				14. MOTHER'S MAIDEN NAME <b>ROSETTA LEONARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>455-50-58</b>		INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>CARCINOMA OF STOMACH</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>WASHINGTON</b>	(County) <b>WASHINGTON</b>	(State) <b>D.C.</b>		
21. I certify that I attended the deceased from <b>APRIL 15, 1960</b> to <b>JUNE 3, 1960</b> , that I last saw the deceased alive on <b>3 June 1960</b> , and that death occurred at <b>755 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Reginald P. Monanus</b> M.D.		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b>		DATE SIGNED <b>3 JUNE 60</b>			
PHYSICIAN'S NAME (Type) <b>REGINALD P. MONANUS, CAPT USAF (MC) ANDREWS AIR FORCE BASE, WASHINGTON 25 DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-6-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. WORTH TEXAS</b>		22d. LOCATION (City, town, or county) (State) <b>TEXAS</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>B.F. TAYLOR</b> <b>609 6TH ST. N.W. D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the funeral director, and completely filled by the attending physician and completely filled by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7287  
CERTIFICATE OF DEATH

07224

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cabaret, Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Cabaret, Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rt 2</i>		d. STREET ADDRESS <i>Rt 2</i>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Higgs</i> Last <i>Higgs</i>		4. DATE OF DEATH Month <i>June</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31, 1889</i>
9. AGE (In years last birthday) <i>70</i> yrs		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General Contractor</i>	
11. BIRTHPLACE (State or foreign country) <i>Staunton, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Higgs</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Painter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes WW I</i>		16. SOCIAL SECURITY NO. <i>WW I</i>	
17. INFORMANT <i>WW I</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>5 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1/73</i> to <i>6/7</i> , 1960, that (I) (we) last saw the deceased alive on <i>6/7</i> , 1960 and that death occurred at <i>6/7</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>J. M. Warren</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, OR DISPOSITION (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Vanderson, Laurel, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 14 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

X

7288

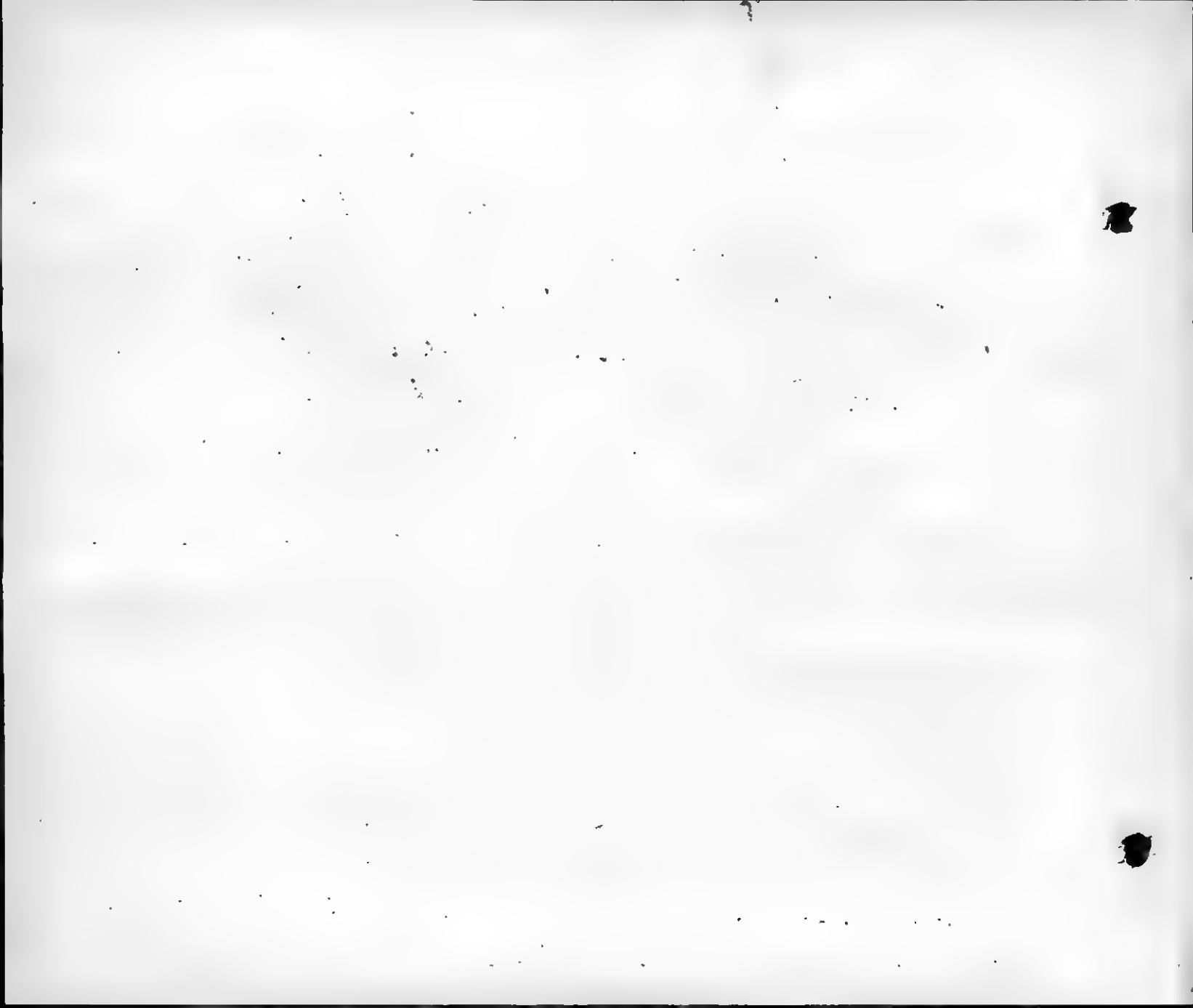
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RT. 2 - Box 127</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>A.</u> Last <u>Hill</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17 - 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Quade</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>  </u>	
INFORMANT <u>William C. Hill</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Demigle Cardio-vascular Atherosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-15</u> , 19 <u>55</u> , to <u>6-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-29</u> , 19 <u>60</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Dabson</u> M.D.		DATE SIGNED <u>6-29-60</u>	
PHYSICIAN'S NAME (Type) <u>Richard H. Dabson</u>		<u>Baltimore Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>July 5-60</u>	<u>Cedar Hill Cemetery</u>	<u>Switzland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Bous</u> ADDRESS <u>1661-9d Hope Rd SE Washington</u>		24a. RECEIVED BY REGISTRAR DATE <u>JUN 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 4

## 7227

07226..

1. PLACE OF DEATH a. COUNTY <b>Princes Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>9 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission on) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>11103 Conti Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Shigeru</b> Middle <b>Horiuchi</b> Last <b>Horiuchi</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Japanese</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-9-1883</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owned own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Japan</b>		12. CITIZEN OF WHAT COUNTRY? <b>Japan</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Harold Horiuchi, 11103 Conti Place</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960</b> to <b>June 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>6/10 1960</b> , and that death occurred <b>9:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. John P. Clum</b> <b>Dr. Carlos C. Sera</b>		22b. DATE SIGNED <b>6/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John P. Clum / Carlos C. Sera</b>		22d. ADDRESS <b>6110 43rd Ave. Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>6/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>	23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Giska</b>		25. REC'D BY REGISTRAR <b>DATE JUN 17 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

37.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7228

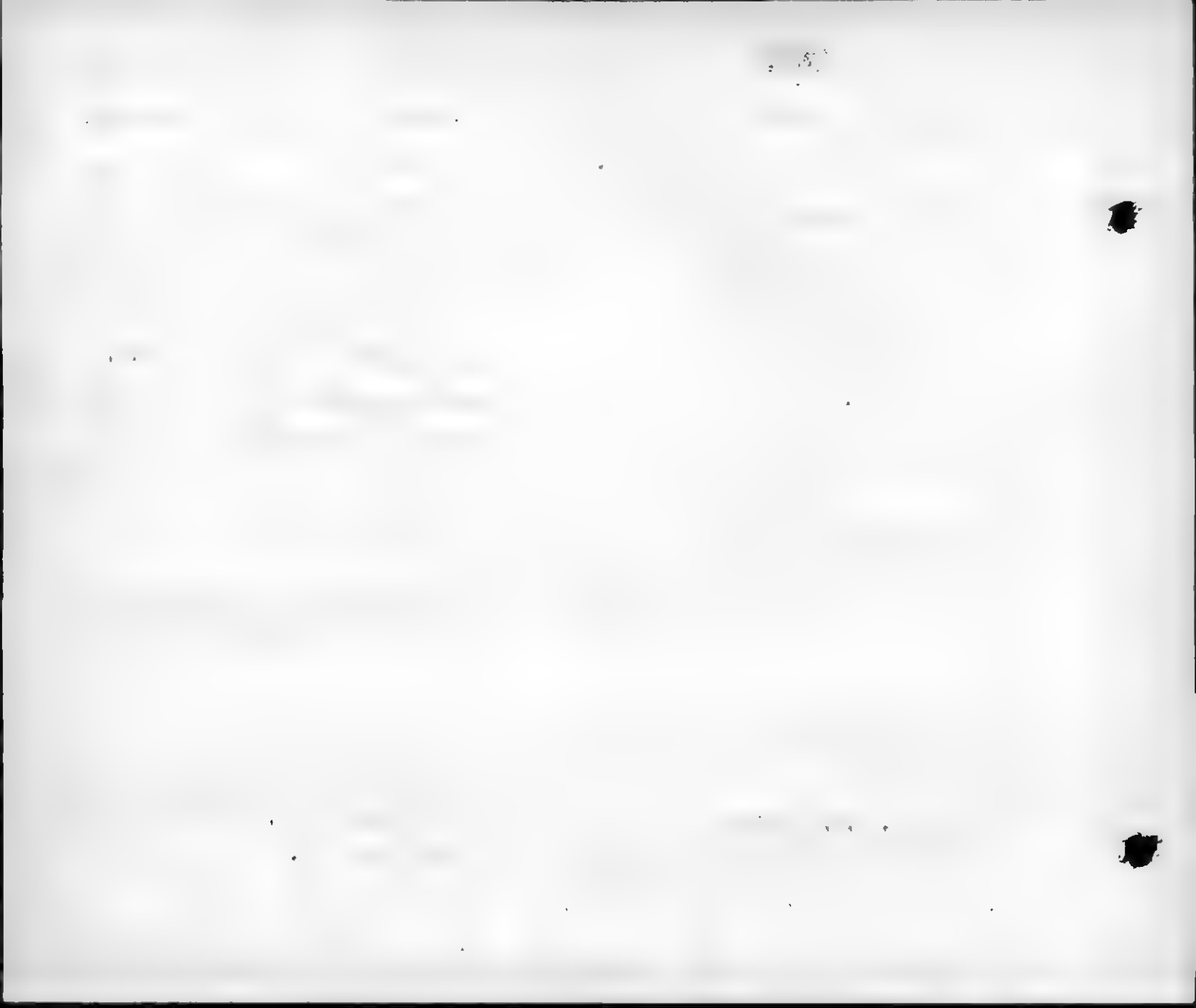
## CERTIFICATE OF DEATH

Reg. Dist. No. 18324

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 30 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH June 19 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 June 1960	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U./S.A.	
13. FATHER'S NAME Scott B.		14. MOTHER'S MAIDEN NAME Eleanor A. nn Rhel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT Mother		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 750x DUE TO <u>Acutecephalitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 1960, to June 19 1960, that I last saw the deceased alive on June 19 1960, and that death occurred on June 19 1960, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dr. J.M. Frawley M.D. 6505 Baltimore Ave. PHYSICIAN'S NAME (Type) James M. Frawley College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF June 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Prince Georges General		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR DATE JUL 25 1960	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

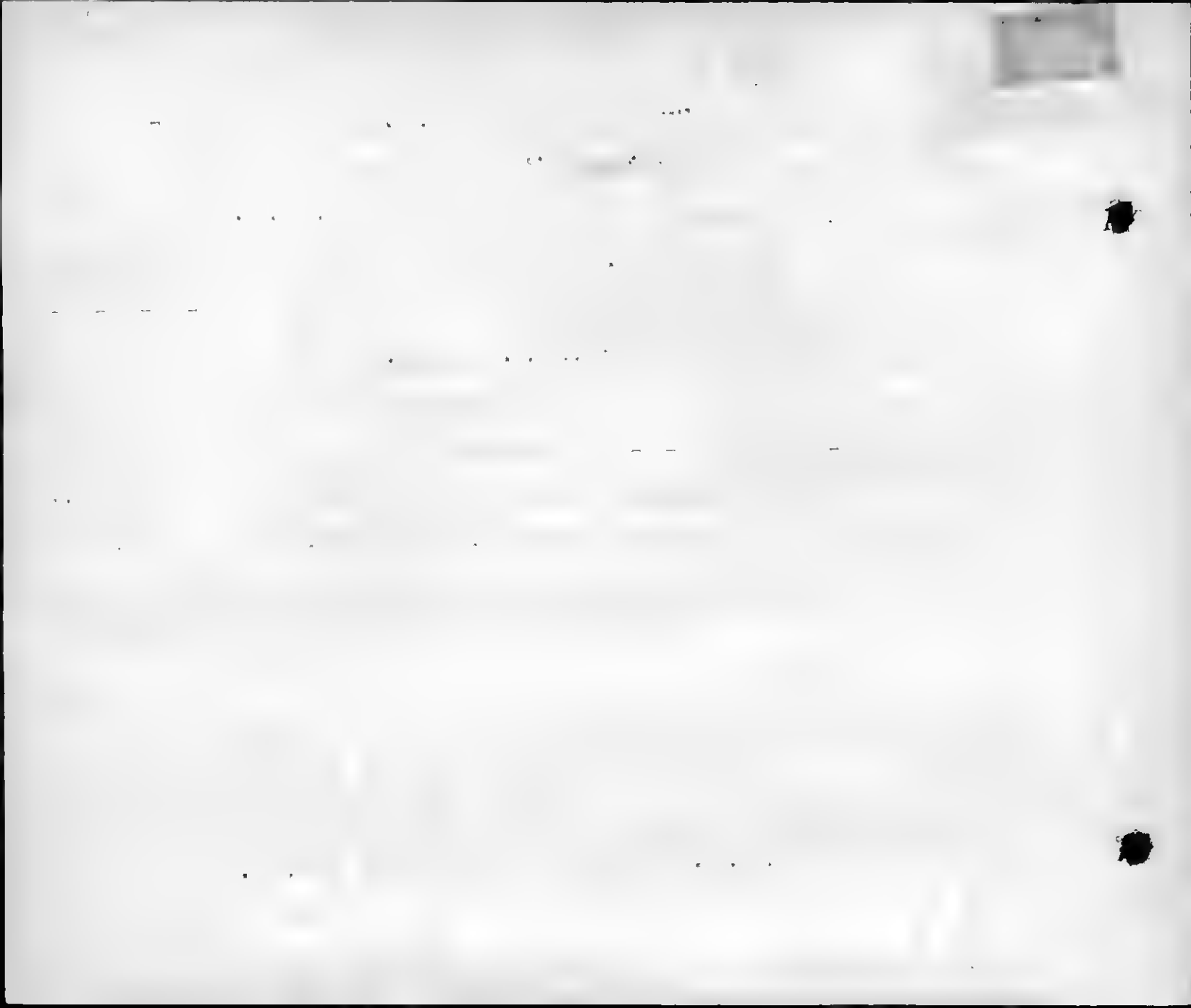


may be reviewed by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the funeral director's name and address. The State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 07227

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (If deceased lived a. STATE <b>D. C.</b>		If institution Residence before admission) b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>3 yrs., 2 mos., &amp; 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>607 6th St., S. W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>John H. Hurley</b>		First Middle Last		4 DATE OF DEATH <b>6 20 19 60</b>		Month Day Year	
5. SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>5/1/05</b>	
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Conservatory</b>		11. BIRTHPLACE (State or foreign country) <b>3720 Nichols Ave., S.E. La.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tom Hurley</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Pervias</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1929-1931</b>		17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive pulmonary hemorrhage</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <b>Pulmonary tuberculosis, far advanced, active</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min., 4 years 5 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>4/19</b> <b>19 57</b> , to <b>6/20</b> <b>19 60</b> that (I) (we) last saw the deceased alive on <b>6/20</b> <b>19 60</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Moe Weiss</b>		M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/20/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, or EXPOSURE (Specify) <b>EXPOSURE</b>		23b. DATE THEREOF <b>6/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Mem. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>300-4th St. N.E.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

7265

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - 20 - 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp.</u>				d. STREET ADDRESS <u>1923 18<sup>th</sup> St., S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Andrew</u> Last <u>Kellenberg</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>4-14-98</u>	9. AGE (In years last birthday) <u>62</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - PLUMBER - US GOVT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Kellenberg</u>				14. MOTHER'S MAIDEN NAME <u>Frances Lammers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia &amp; hepatic cancer</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Ca to liver</u> DUE TO (c) <u>Probable primary Ca in communication with ?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-18-60</u> , 19 <u>60</u> , to <u>6-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-18</u> , 19 <u>60</u> , and that death occurred at <u>5-29</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R F Wilkinson</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale Md.</u> DATE SIGNED <u>6/18/60</u>			
PHYSICIAN'S NAME (Type) <u>R F Wilkinson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07229

Reg. Dist. No.

7290

1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geos.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Seat Pleasant</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5970 Addison Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Holary</u> Last <u>King</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Marks</u>		14. MOTHER'S MAIDEN NAME <u>Susie F. Selby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give way or date of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Ellen King</u> Address <u>5970 Addison Rd SE D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>442</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO <u>2 Years</u> (c) <u>10 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5, 1960</u> , to <u>June 15, 1960</u> , that I last saw the deceased alive on <u>June 15, 1960</u> , and that death occurred at <u>5:07 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D.		ADDRESS (Street, city or town, state) <u>7005 Ritchie Rd SE Wash 22 D.C.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND RA R 600 to MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers &amp; 517-11-51 SE WASH DC</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE JUN 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

25



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Branchville</b>		c. LENGTH OF STAY IN 1b <b>transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Smith's Lake, Smith's Sand and Gravel Pit.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lanham</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>A.</b> Last <b>Lee</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28<sup>th</sup> 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jailer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John P. Lee</b>		14. MOTHER'S MAIDEN NAME <b>Mary Collison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.1</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clifford Alfred Jones; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Drowning</b> (c) <b>DUE TO</b> (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>129</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while swimming in a lake.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4.00 P.M. 6-24-1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lake</b>		20f. (City or town) (County) (State) <b>Branchville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 24, 1960</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-28-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Valley Cent.</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor Sues</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 29 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hines</b>



7258

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY <b>ALEXANDRIA</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>				c. LENGTH OF STAY IN 1b <b>adm 2-22-57</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALMA</b>		First <b>LICHTER</b> Middle <b>MANN</b> Last <b>MANN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-1880</b> 9. AGE (In years last birthday) <b>80</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNKNOWN</b>	
13. FATHER'S NAME <b>EDWARD MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>JANE REED</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>7</b>		INFORMANT <b>HOSP. RECORDS LAUREL SANITARIUM</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART BLOCK (433.0)</b> DUE TO <b>antennosclerotic heart disease (420)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>15 C.O.</b> (c) <b>15 C.O.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL HUNDRED MANY YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction (2) Infantile paralysis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Time, nature of injury in Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2-22-1957</b> to <b>6-16-1960</b> that I last saw the deceased alive on <b>6-16-1960</b> , and that death occurred at <b>4:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. P. Kraemer</b> M.D.				ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b> DATE SIGNED <b>6-16-1960</b>			
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>				<b>LAUREL MARYLAND</b>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>CREMATION</b>		<b>June 20, 1960</b>		<b>FORT LINCOLN CREM.</b>		<b>COLMAR MANOR, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William S. ...</b>				ADDRESS <b>LAUREL, MD</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 21 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

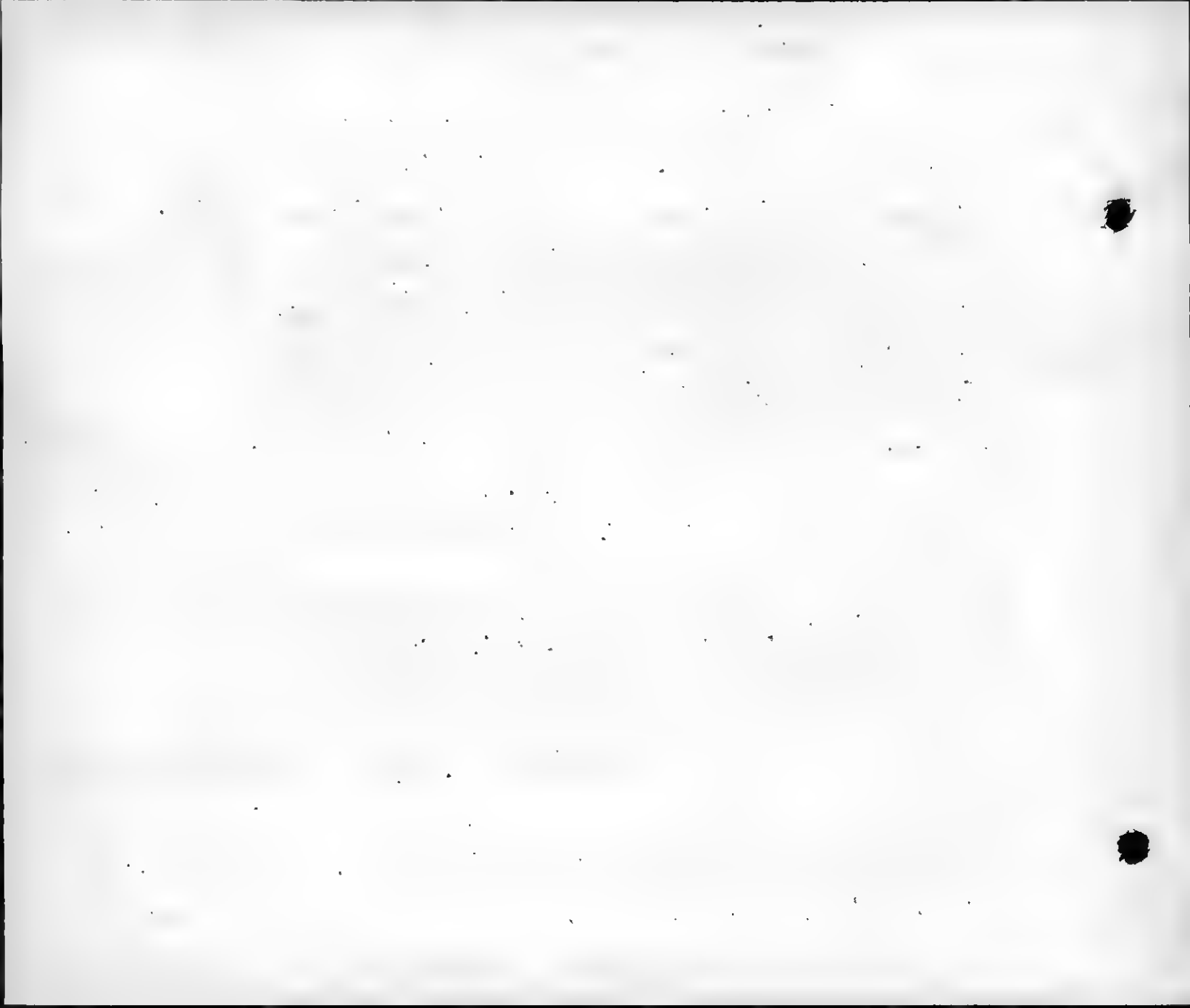
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

07232

7229

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Edmonston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4811 52d Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FRANKLIN LUTZ				4. DATE OF DEATH Month Day Year June 9, 19 60.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Maloney Concrete		11. BIRTHPLACE (State or foreign country) Rochelle, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mark Franklin Lutz				14. MOTHER'S MAIDEN NAME Alie Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO 216-180601		17. INFORMANT Esther Anderson Lutz, Edmonston, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 16 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-10, 1960, to 6-9, 1960, that I last saw the deceased alive on 6-8-60, 19, and that death occurred at 2:10 a.m. from the causes and on the date stated above.							
SIGNATURE John P. Clum M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 6-9-60			
PRINTED NAME (Type) JOHN P. CLUM, M.D.				6110 43d Ave., Hyattsville, Md. 6/9/60.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1960		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7230

## CERTIFICATE OF DEATH

Reg. Dist. No. 07233

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 3903 Perry St., #1	
3. NAME OF DECEASED (Type or print) First Middle Last Emmerich Mantz		4. DATE OF DEATH Month Day Year June 12 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-77
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emmerick Carstens		14. MOTHER'S MAIDEN NAME Helen Geery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Helen R. Hagerty		8 Ashby St. Apt. A. Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL INFARCTION DUE TO HYPERTENSION (b) Generalized atherosclerosis DUE TO DIABETES MELLITIS (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE LEFT HIP		INTERVAL BETWEEN ONSET AND DEATH 1 week YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1940, to JUNE 1960, that I last saw the deceased alive on JUNE 12, 1960, and that death occurred at 8:20 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin A. Miller M.D.		ADDRESS (Street, city or town, state) 3824-34th Mt Rainier 6/13/60	
PHYSICIAN'S NAME (Type) Dr. B. Miller M.D.		Mt. Rainier., Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUN 16 60		Charles L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

Reported to and Released by Dr. J. J. Maloney, Coroner

VS A15 (4)  
ISM 9/58

22

40



7292

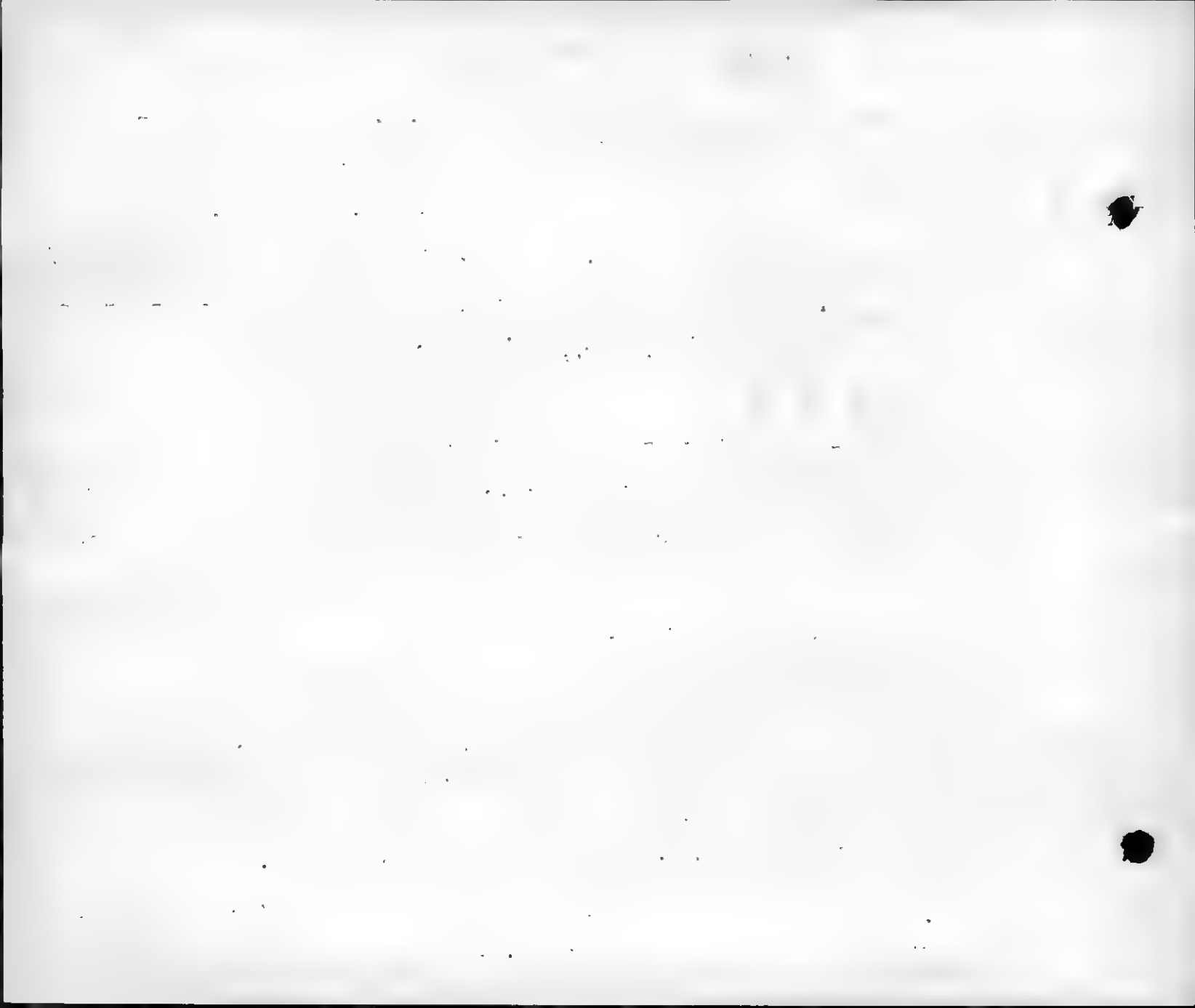
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>7 months &amp; 17 days</b>				d. STREET ADDRESS <b>1214 N. Capital St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carmen</b> Middle <b>G.</b> Last <b>Mazzetti</b>				4. DATE OF DEATH Month <b>6</b> Day <b>7</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/2/94</b>		9. AGE (In years last birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Tile &amp; Marble Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓	
13. FATHER'S NAME <b>Camello Mazzetti</b>				14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-07-4646</b>		INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary hemorrhage</b> <b>002</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary fibrosis and emphysema</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>7 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/21/ 1959</b> , to <b>6/7/ 1960</b> , that I last saw the deceased alive on <b>6/7/ 1960</b> , and that death occurred at <b>12:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>6/7/60</b> ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> <b>Glenn Dale, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Albans</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony ...</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7231

## CERTIFICATE OF DEATH

07235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Christopher L.J. McCaffrey</b>		4. DATE OF DEATH Month Day Year <b>June 14 19 60</b>	
5 SEX <b>Male</b>	6. CO. OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Sept. 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - District Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Christopher McCaffrey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Malone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. M. #1</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive G.I. Hemorrhage</b> DUE TO <b>Portal cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office b. d. g., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , 19 to <b>June 13, 1960</b> , that I last saw the deceased alive on <b>June 13, 1960</b> , and that death occurred at <b>2:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon W. Kelley</b>		ADDRESS (Street, city or town, state) <b>Hyatts, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. G. Kelley., M.D.</b>		DATE SIGNED <b>6/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kelley's Funeral Home</b>		ADDRESS <b>Indi</b>	
24a. REC'D BY REGISTRAR <b>Arthur E. Kline</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	
DATE <b>JUN 17 '60</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

may be returned by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2500

2500

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## CERTIFICATE OF DEATH

Reg. Dist. 07236

7232

1 PLACE OF DEATH a COUNTY <i>Prince Georges</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE <i>md</i> b COUNTY <i>Prince Georges</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seatonsville</i>		c LENGTH OF STAY IN 1b <i>HOA</i>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Hospital</i>		e STREET ADDRESS <i>19605 Woodbury St</i>	
3 NAME OF DECEASED (Type or print) <i>FREDERICK JOHN McC LURE</i>		4. DATE OF DEATH <i>June 19, 1960</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 2-1891</i>
9 AGE (In years last birthday) <i>69</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>safeway stores</i>	
11 BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13 FATHER'S NAME <i>John Mc Clure</i>		14. MOTHER'S MAIDEN NAME <i>Rose Landau</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Informant</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction, Acute, massive.</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Barry Rosenberg</i>		ADDRESS (Street, city or town, state) <i>5102 Annapolis Rd Bladensburg Md 6/19/60</i>	
PHYSICIAN'S NAME (Type) <i>BARRY ROSENBERG</i>		DATE SIGNED <i>Bladensburg, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/21/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23 FUNERAL DIRECTOR'S SIGNATURE <i>Fischer Sons Hyattsville Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>DATE JUN 22 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i>	

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7293

## CERTIFICATE OF DEATH

Reg. Dist. No.

07237

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights				c. LENGTH OF STAY IN 1b 9 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Rutan St				d. STREET ADDRESS 6200 Rutan Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) (Tessie) Teresa First Middle Last Mc Cluskey				4. DATE OF DEATH Month June Day 1 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept 1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Eder				14. MOTHER'S MAIDEN NAME Kathy Fechler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Peter J. Mc Cluskey (Husband) Same as # 2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> 260A DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-1 1939 to 6-2 1960, that I last saw the deceased alive on 6-1 1960, and that death occurred on M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE A. Deitz M.D.				Hyattsville, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 6/4/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE JUN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

42





7294

## CERTIFICATE OF DEATH

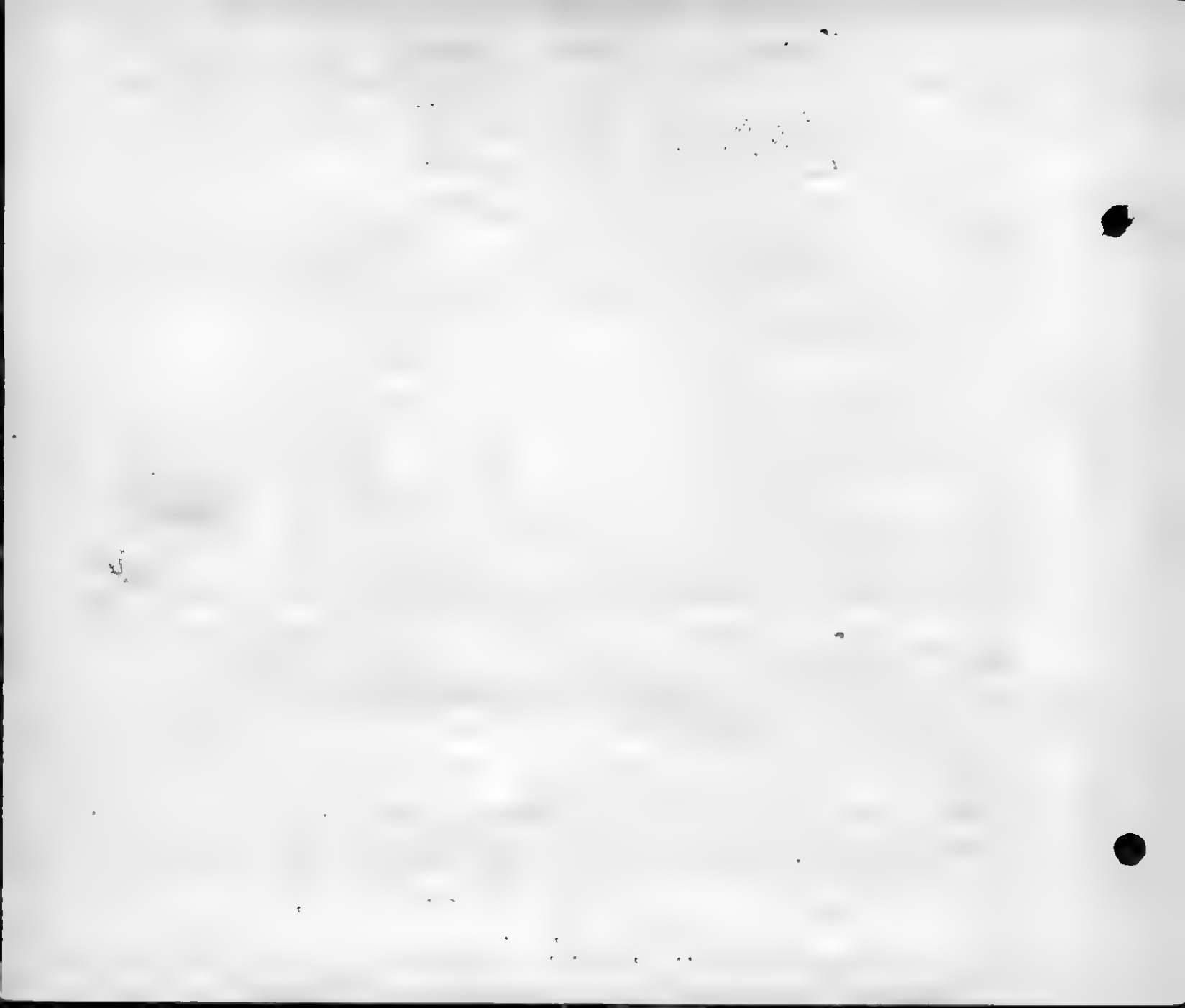
Reg. Dist. No. 07238

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB MD		d. STREET ADDRESS Midway Trailer Court	
3. NAME OF DECEASED (Type or print) First Middle Last McCONNIE NEWBORN		4. DATE OF DEATH Month Day Year JUNE 3 19 60	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 JUNE 1960
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR: Months Days Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT A McCONNIE		14. MOTHER'S MAIDEN NAME SHIRLEY ELSIE SNYDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT ROBERT A McCONNIE, MIDWAY TRAILER CT, WALDORF MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 3 June, 19 60, and that death occurred at _____ P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Vincenzo P. Ringrose, Jr. M.D. USAF HOSP ANDREWS, ANDREWS AFB WASH 25, DC			
ACTUAL SIGNATURE VINCENZIAPPA'S NAME (Type) VINCENT P. RINGROSE JR CAPT USAF MC USAF HOSP ANDREWS, ANDREWS AFB WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 8, 1960	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC		24a. REC'D BY REGISTRAR DATE JUN 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050241XV0



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

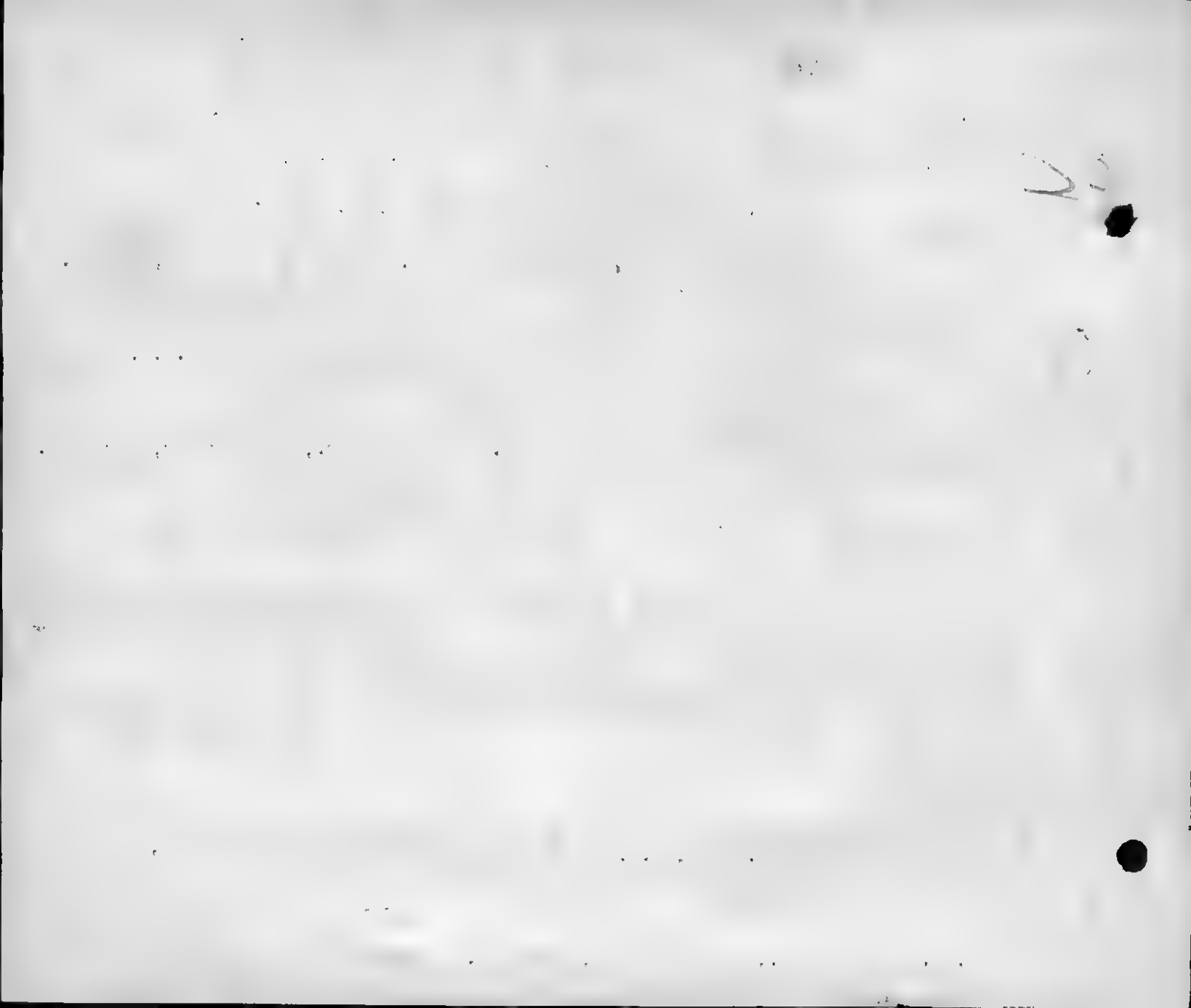
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
M. 7/19

## 07239

## MEDICAL CERTIFICATION

VS. A15ME  
■M 7/■9



FOR STATE  
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

7233

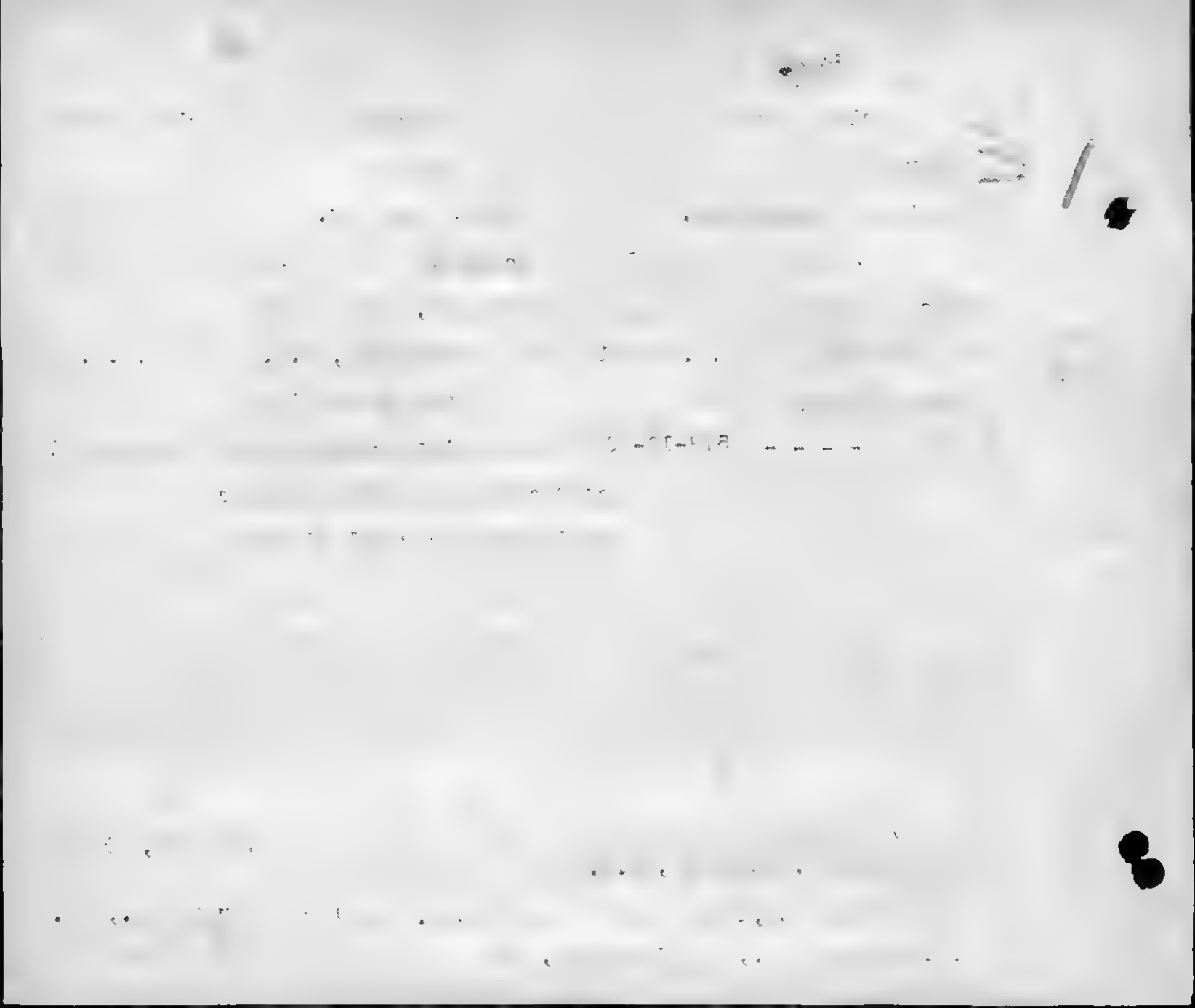
07240

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>DOA Prince George Hosp.</b>		d. STREET ADDRESS <b>6202 State St.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Paul</b> Last <b>McKENNEY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Transit Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McKenny</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen King</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-7669</b>	
17. INFORMANT <b>Mrs Pauline McKenny (Wife)</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 20, 1960</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Prince Georges Co., Md.</b>	
23. FUNERAL DIRECTOR <b>W.W.Chambers Co.,</b>		ADDRESS <b>Riverdale, Md</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	
DATE <b>JUN 22 '60</b>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

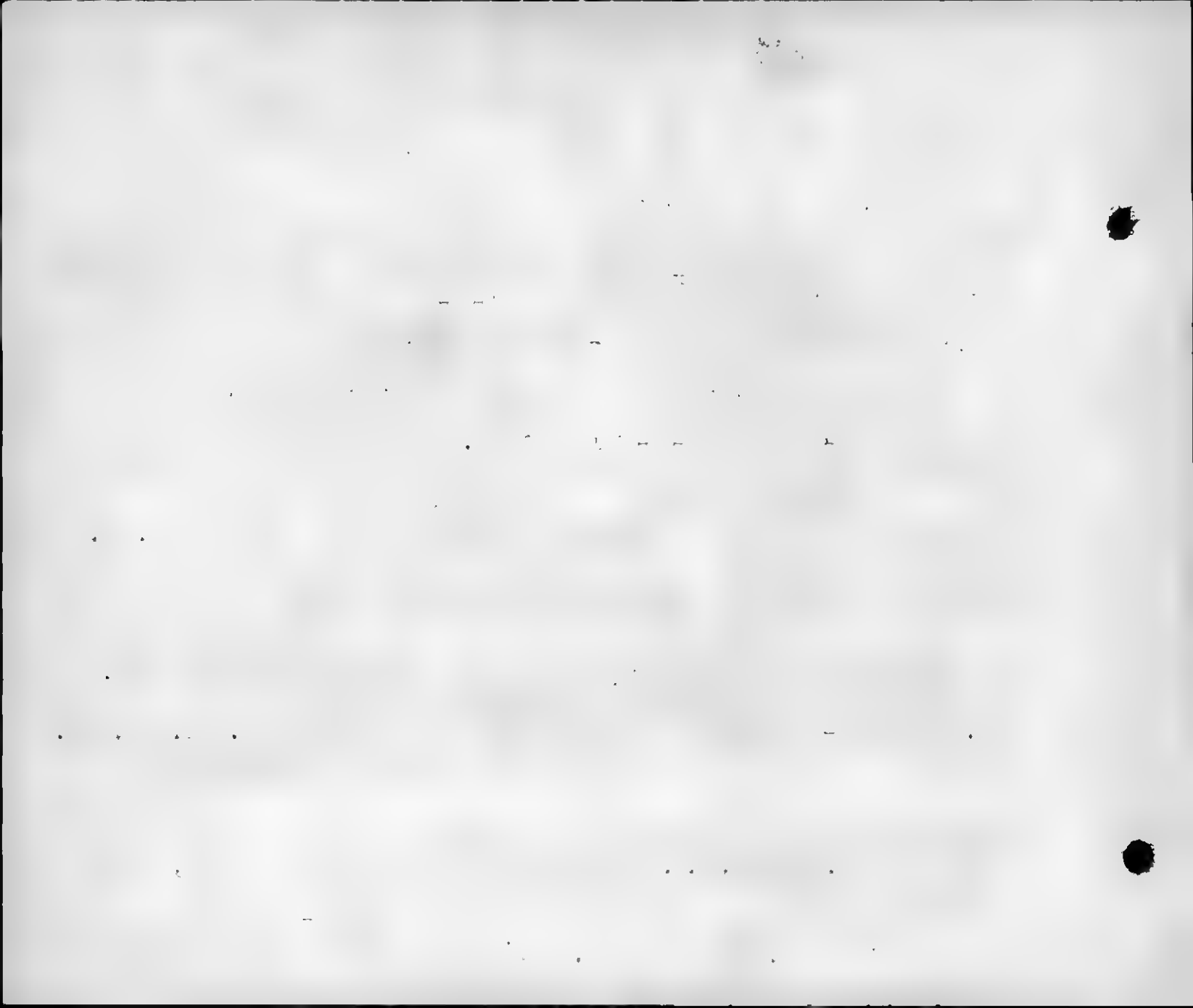
07241

Reg. Dist. No.

7234

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Houston</b> Last <b>McNinch</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-33</b>	
9. AGE (In years last birthday) <b>26 yrs.</b>		IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b>		IF UNDER 24 HRS. Hours <b>26</b> Min. <b>26</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Field</b>			
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Casper Le Roy McNinch</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Hubbard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1951-55 54</b>		17. INFORMANT <b>Helen M. McNinch; same address as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b></p> <p><b>815X</b> DUE TO <b>Compound, comminuted fracture of skull, pelvis and r. leg.</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____</p> <p>DUE TO (c) _____</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of an automobile in collision with a motor cycle.</b>			
20c. TIME OF INJURY Month, Day, Year <b>2.10 6-11- 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Accokeek, Md. Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 11, 1960</b>			
22a. NAME OF CEMETERY OR CREMATORY <b>Ottawa Hills Memorial Park</b>		22b. DATE THEREOF <b>6/13/60</b>		22c. LOCATION (City, town, or county) (State) <b>Toledo, Ohio</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>JUN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use prior to burial, cremation, or removal.





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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7266

CERTIFICATE OF DEATH

Reg. Dist. No.

07242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) Ireland Memorial Hosp				d. STREET ADDRESS 4902 Navahoe St			
3. NAME OF DECEASED (Type or print) Anna Cecelia Middleton				4. DATE OF DEATH Month 6 Day 15 Year 1960			
5. SEX F	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1921	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DC	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Barland				14. MOTHER'S MAIDEN NAME Mary Mack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT WILLIAM BROOKS				Address 4902 NAVAHOE ST. COLLEGE PARK, MD.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic abscess and thrombosis							
(c) Post partum infection							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 11, 1960, to June 15, 1960, that I last saw the deceased alive on June 15, 1960, and that death occurred at 8 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Theo. Zegarra M.D.				ADDRESS (Street, city or town, state)			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-20-60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
				22d. LOCATION (City, town, or county) (State) FT. MYER, VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE Alex J. Lopez				ADDRESS 414-15th St. S.E.		24a. REC'D BY REGISTRAR DATE JUN 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07244

7201

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3710 Quincy Street</b>				d. STREET ADDRESS <b>3710 Quincy Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Burdick</b> Last <b>Mitchell</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-16-06</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Flora Gold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>196-01-5084</b>		17. INFORMANT Address <b>Vera Mitchell; same address as # 2.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b>							
DUE TO <b>Metastatic carcinoma</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO <b>Carcinoma of prostate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>June 7, 1960</b>	<b>Rock Creek Cemetery</b>		<b>Washington D.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. H. H. H.</i>				24a. REC'D BY REGISTRAR DATE <b>JUN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. H. H.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or removal.

1948

1948

1948

1948

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

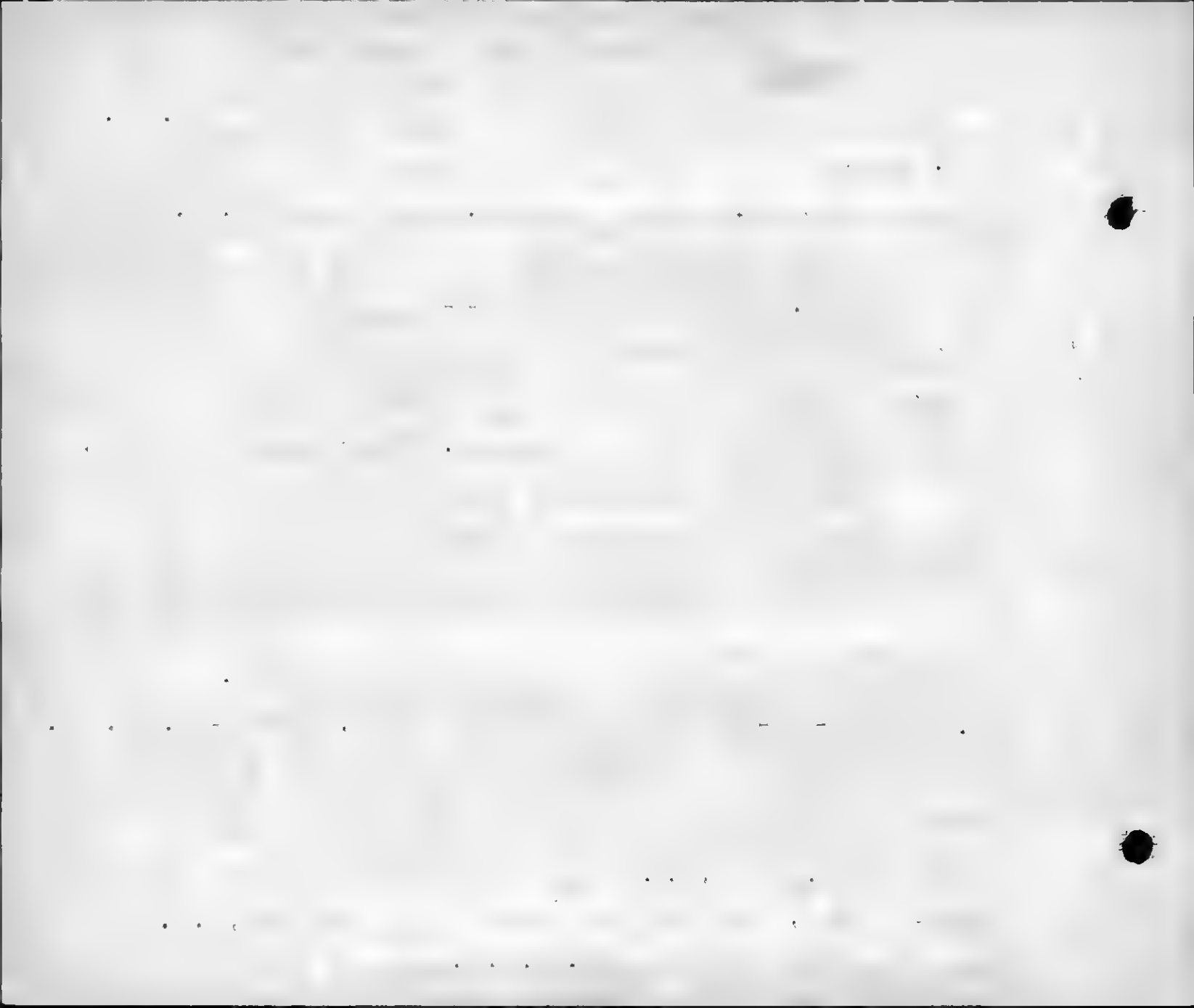
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07245**

7202

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N. Brentwood</b>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4500 Block 41st Ave.</b>				d. STREET ADDRESS <b>Rt. 1 Box 358 A Lanham, Md.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Thomas Walter Moore</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>June 29 1960</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Col.</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6-6-11</b>	
<b>9. AGE</b> (In years last birthday) <b>49 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give name of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward Moore</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mattie Hawkins</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> 		<b>17. INFORMANT</b> Address <b>Regina E. Harling; same address as # 2.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b>  <b>DUE TO</b>  <b>Gunshot wound of chest</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot wound inflicted by another person.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>3:20 p.m. 6-29-60</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		<b>20f. (City or town) (County) (State)</b> <b>N. Brentwood--Pr. Geo. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>DATE SIGNED</b> <b>June 29, 1960</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>July 2, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Washington, D. C.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>				<b>ADDRESS</b> <b>414 15th. St. S. E.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUL 5 '60</b>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7197

Item 2 filed 6-26-60 at

## CERTIFICATE OF DEATH

07246

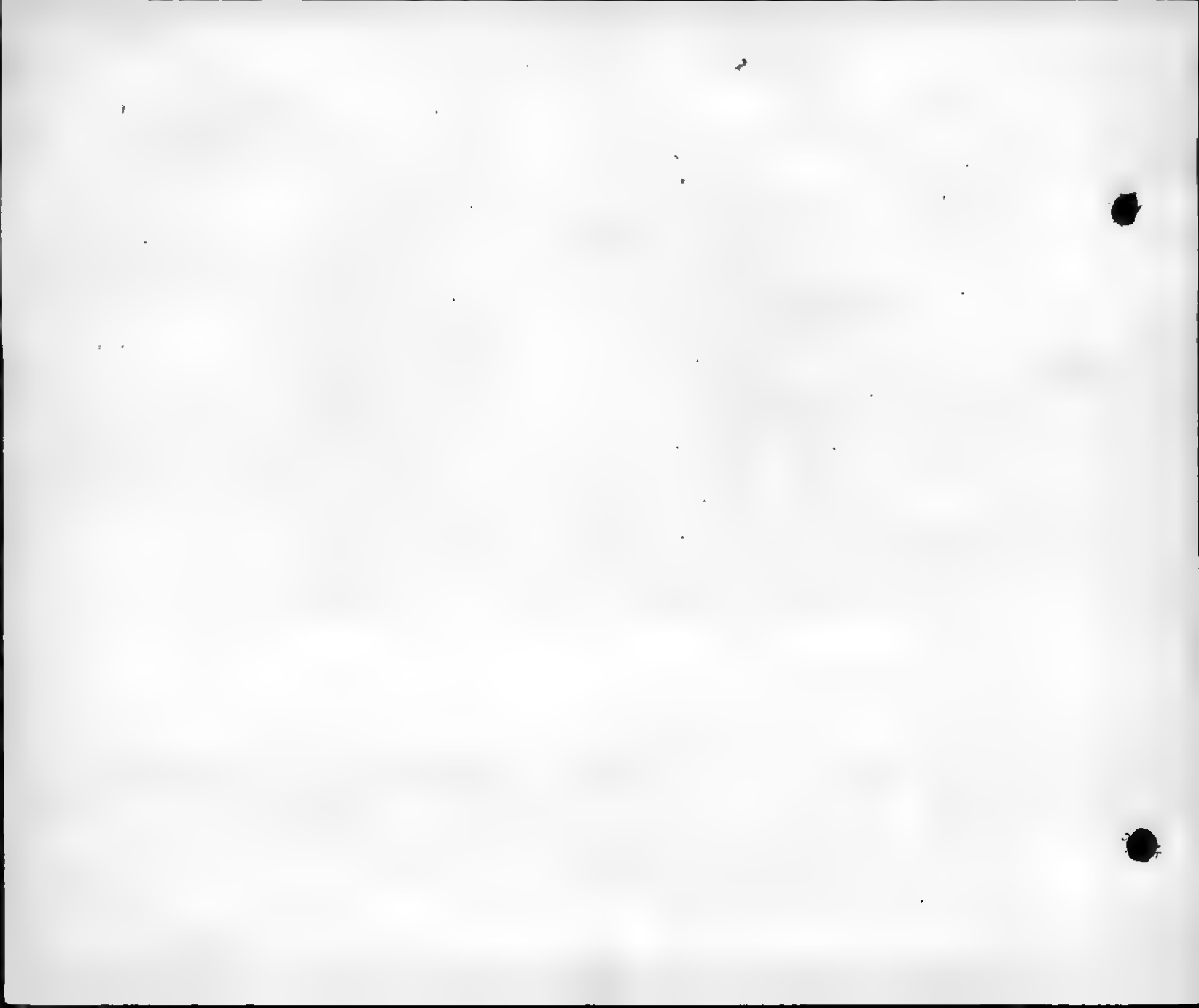
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bell's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond John Nasierowski		4. DATE OF DEATH Month 6 Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-60
9. AGE (In years last birthday) yrs. 20		10. IF UNDER 1 YEAR Months 0 Days 0	
11. BIRTHPLACE (State or foreign country) Maryland, Balt. City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddeus W. Nasierowski		14. MOTHER'S MAIDEN NAME Jane Dorothy Depuy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nursing Home Record		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mongoloidism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1960, to June 27, 1960, that I last saw the deceased alive on 6-27-60, 1960, and that death occurred at 8:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6-28-60 ACTUAL SIGNATURE Thomas A. Christensen M.D. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D. 6905 Baltimore Blvd., College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Dorsch Sons Hyattsville, Md.		24. REC'D BY REGISTRAR JUL 5 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7259

## CERTIFICATE OF DEATH

07247

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institut on Residence before admission) o. STATE <u>VIRGINIA</u> COUNTY <u>NORTH HAMPTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> adm. 8-27-59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS _____	
<b>3. NAME OF DECEASED</b> (Type or print) <u>LOUISE</u> First <u>J. NOTTINGHAM</u> Middle Last		<b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>17</u> Year <u>19 60</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1879</u>
9. AGE (In years lost birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESS-WOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST-OFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>SAMUEL JARVIS</u>		14. MOTHER'S MAIDEN NAME <u>ELISABETH ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA (491)</u> (b) <u>Apoplexy (334)</u> (c) <u>cerebral arteriosclerosis with</u> <u>psychotic reaction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL days</u> <u>11 days</u> <u>several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>8-27-</u> 19 <u>59</u> to <u>6-17-</u> 19 <u>60</u> that I last saw the deceased alive on <u>6-17-</u> 19 <u>60</u> , and that death occurred at <u>5:10</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith P. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>6-17-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 18, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal</u>	22d. LOCATION (City, town, or county) <u>Eastville</u> (State) <u>Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Womalden</u> ADDRESS <u>James Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be carried with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07248

7296

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma PK</u> <u>1517</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Branch Nursing Home</u>		d. STREET ADDRESS <u>7902 - Flower Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lydia Dato</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>69</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Christensen</u>		14. MOTHER'S MAIDEN NAME <u>Louise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 24, 1959</u> to <u>June 25, 1960</u> , that I last saw the deceased alive on <u>June 21, 1960</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>254 Davis Ave Tak. PK.</u> DATE SIGNED <u>6/25/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal NW</u>		ADDRESS <u>254 Canal NW</u>	
24a. REC'D BY REGISTRAR <u>J. Arthur Walters</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7297

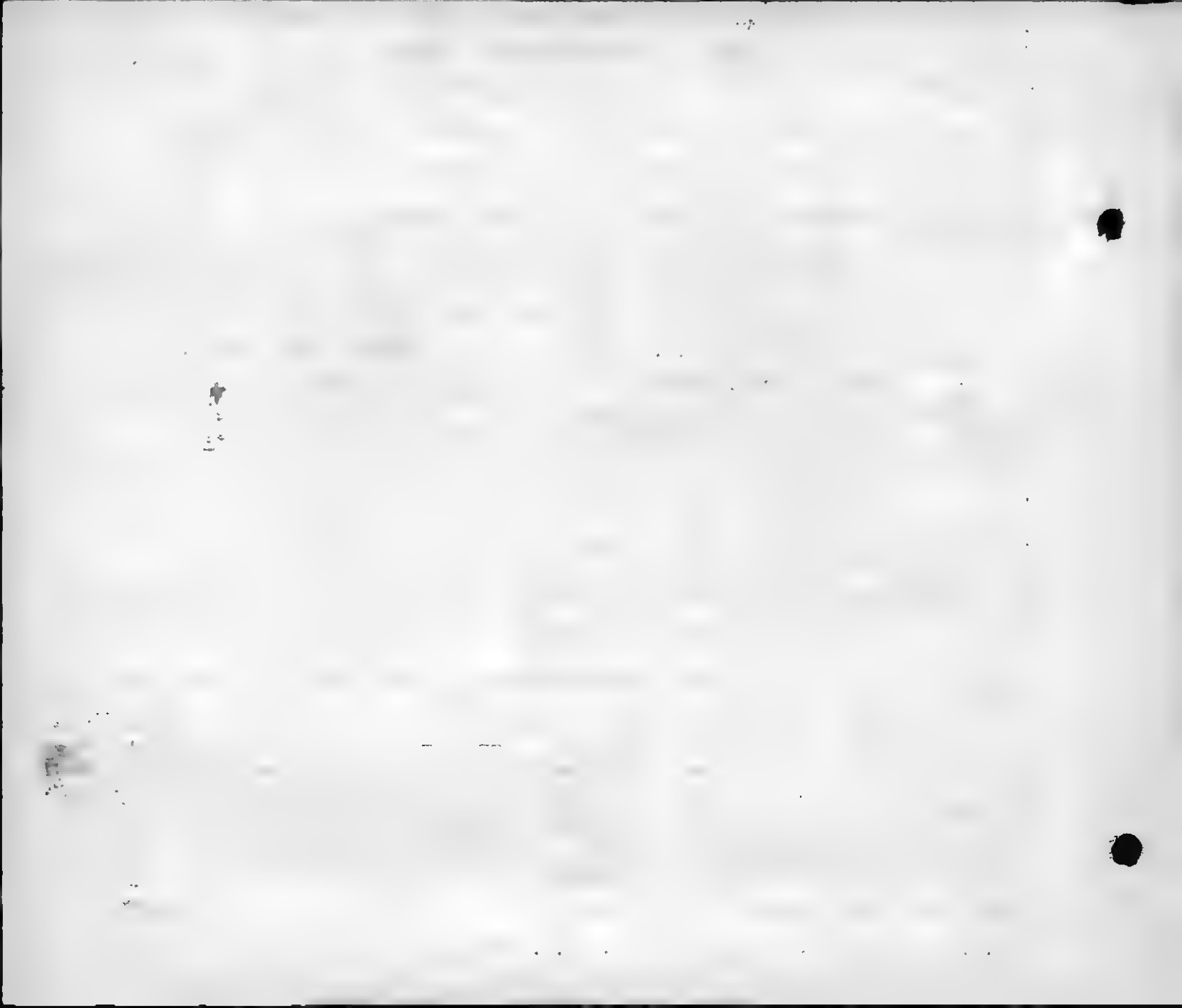
CERTIFICATE OF DEATH

Reg. Dist. No. 07249

1. PLACE OF DEATH a. COUNTY Prince GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DIST. of COLUMBIA b. COUNTY 4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL UPPER MARLBORO NA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS ANACOSTIA WASH 25 DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 5 DOA USAFH ANDREWS AAFB				d. STREET ADDRESS UNKNOWN			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES BARTLETT ORMSBEE				4. DATE OF DEATH Month Day Year JUNE 5 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 SEPT 1939	
9. AGE (In years last birthday) 20 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILITARY SERVICE		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) Michigan U.S.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Charles ORMSBEE			
14. MOTHER'S MAIDEN NAME Beulah (unknown)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES JAN. 13, 1959			
16. SOCIAL SECURITY NO. 372-38-4393				17. INFORMANT Address Naval Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SKULL FRACTURE DUE TO AUTOMOBILE ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in automobile which left road and struck tree.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:15 JUN 5 19 60				20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET	
20f. (City or town) UPPER MARLBORO				20g. (County) P.G.		20h. (State) MD	
21. I certify that I attended the deceased from DOA, 19 to 19, that I last saw the deceased alive on 5 JUNE, 19 60, and that death occurred at 3:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 6-6-60 ANDREWS AFB WASH 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				22b. DATE THEREOF 6-7-60		22c. NAME OF CEMETERY OR CREMATORY Flint Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co., 1400 Chapin St., N.W., Wash DC				24a. REC'D BY REGISTRAR JUN 7 '60		24b. REGISTRAR'S SIGNATURE	

Prince George Co. Medical Examiner, Dr. Boyd, notified and waived jurisdiction.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7235

CERTIFICATE OF DEATH

Reg. Dist. No.

07250

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>36 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Rose Anna Osterman</b>		4. DATE OF DEATH Month Day Year <b>June 23 - 1960</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/1886</b>
9. AGE (In years lost birthday) <b>74</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Retired Naval Gun Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Handy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Coombs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>May C. Puckett</b>		4403 <sup>address</sup> Van Buren st. University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Major - heart infarction</b> DUE TO <b>20.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <b>6/21 1960</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/21</b> , 19 <b>60</b> , to <b>6/23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6/22</b> , 19 <b>60</b> , and that death occurred at <b>5:30</b> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>4410 74 Ave 6/23/60</b>	
PHYSICIAN'S NAME (Type) <b>F. E. MESSER M.D.</b>		DATE SIGNED <b>6/23/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07251

7236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>5205 Addison Chapel Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b></b> Last <b>Outlaw</b>				4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-13</b>		
				9. AGE (in years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		
						IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe layer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Outlaw</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Gilliam</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2</b>		17. INFORMANT <b>Shirley Outlaw; same address as # 2.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>910.5</b> DUE TO <b>Crushed chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was working in a ditch when side bank gave way covering deceased.</b>					
20c. TIME OF INJURY Month, Day, Year <b>10.20.60</b> <b>6-8</b> <b>'60</b>			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Glen Arden Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>June 8, 1960</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>		22b. DATE THEREOF <b>6-12-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b></b>		22d. LOCATION (City, town, or county) (State) <b>Merryhill N.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Washington</i>				ADDRESS <b>4925 Deane Ave NE.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 13 '60</b>		
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. For to burial, cremation, or removal.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

7237

Reg. Dist. No. 07252

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pr. Geo.</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28 District Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				/d. STREET ADDRESS <b>7400 Walker Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>Robert</b> Last <b>Patterson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-00</b>		9. AGE (in years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Howit Concrete Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1918-1934</b>		17. INFORMANT <b>Mary Ruth Patterson; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b></p> <p><b>4445</b> DUE TO <b>Cardiovascular renal disease</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____</p> <p>DUE TO (c) _____</p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>June 12, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W H Chambers</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the failure to file, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar to burial, cremation, or removal.

28.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7238

CERTIFICATE OF DEATH

07253

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC (P.O. Zone 27)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rev. Otto Penter		4. DATE OF DEATH Month Day Year June 1 19 60	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-88
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Minister		10b. KIND OF BUSINESS OR INDUSTRY Protestant	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Penter		14. MOTHER'S MAIDEN NAME Theresa (unknown)	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 289-01-9960	
17. INFORMANT Kathryn C. Penter-#2d. Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Brucella pneumonia			
(b) Cerebellar hemorrhage.			
(c) Arterio-sclerotic heart disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Pancreas.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 26, 1960, to JUNE 1, 1960, that (I) (we) last saw the deceased alive on JUNE 19 60, and that death occurred at 8:25 pm from the causes and on the date stated above.			
22a. SIGNATURE Charles C. Hageage		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES C HAGEAGE		22d. ADDRESS CHEVERLY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-4-60	
23c. NAME OF CEMETERY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Paxon Inc		25a. REC'D BY REGISTRAR DATE JUN 6 '60	
ADDRESS 317 Pa Ave SE		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

2



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7298

Item 14 Film 265 6-28-60 et

## CERTIFICATE OF DEATH

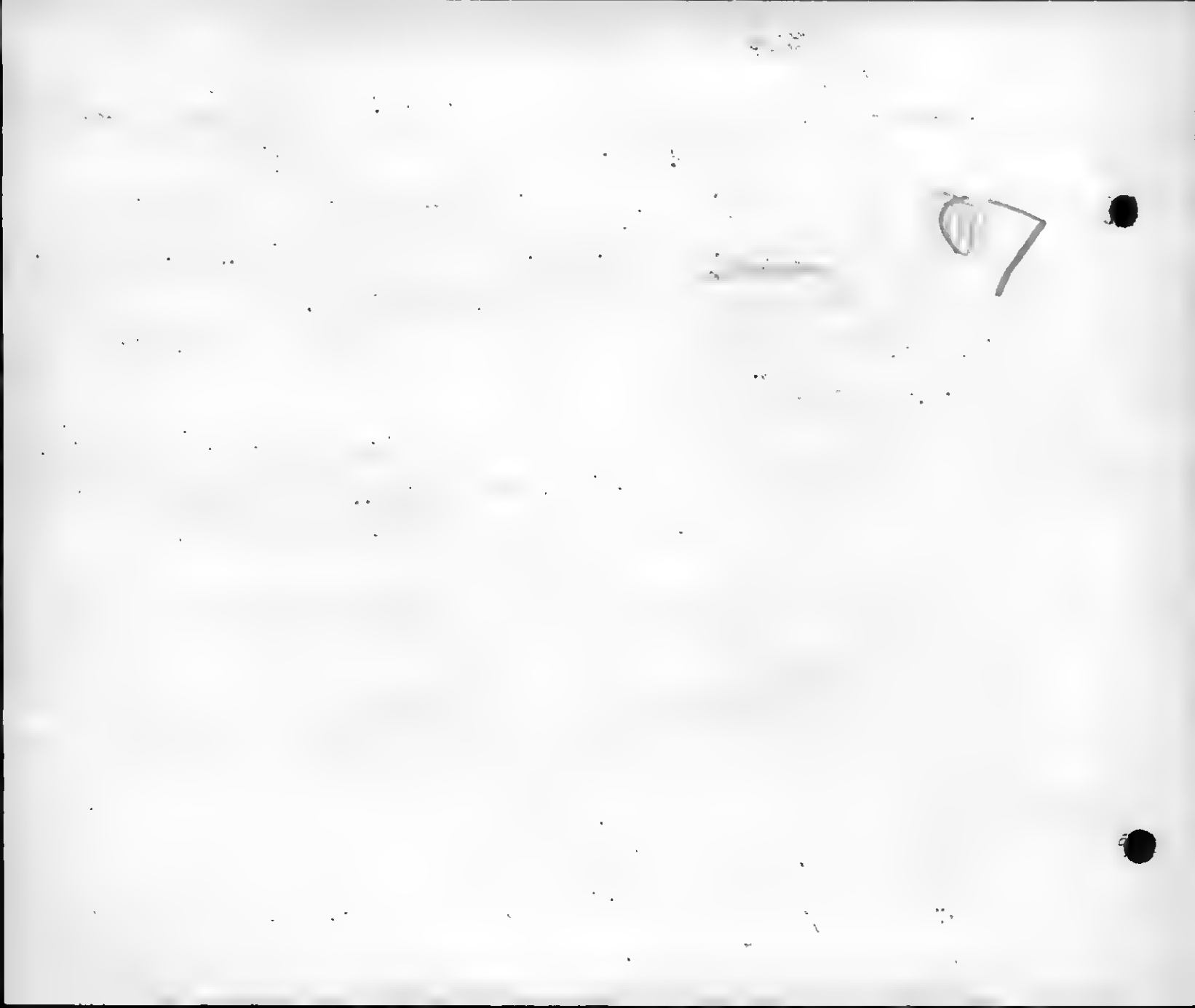
Reg. Dist. No.

07254

1. PLACE OF DEATH a. COUNTY <u>Brandywine</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Princo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Maryland</u>		e. STREET ADDRESS <u>Woodlynd Rd. Clinton Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>PINKNEY</u> Middle <u>THOMAS</u> Last <u>✓</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1883</u>
9. AGE (In years last birthday) <u>77</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pn. Geo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pn. Geo.</u>	
13. FATHER'S NAME <u>Henson Pinney</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Skinner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Rebecca Brown Brandywine Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS 6 YR.</u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>  </u> 19 <u>57</u> to <u>  </u> 19 <u>60</u> (that I last saw the deceased alive on <u>April 1</u> 19 <u>  </u> , and that death occurred at <u>  </u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Kelton</u> M.D.		ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>5/13/60</u>	
PHYSICIAN'S NAME (Type) <u>George J. Kelton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>	22d. LOCATION (City, town, or county) (State) <u>Brandywine Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Kelton</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Clinton L. Harris</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7239

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad Sacorda Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Cheverly</u>	
f. STREET ADDRESS <u>2506 PREST AVE</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET BEATRICE RAHN</u>		4. DATE OF DEATH Month Day Year <u>June 18 1960</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31, 1874</u>
9 AGE (in years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John James Carridon</u>		14. MOTHER'S MAIDEN NAME <u>Bridgett Conlon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>husband</u>		Address <u>Cheverly, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>			
DUE TO <u>155.0</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Adeno CARCINOMA OF COLON</u>			
DUE TO (c) <u>6 mos</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 mos</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>June 18, 1960</u> , that I last saw the deceased alive on <u>June 18, 1960</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3513 Penay ST</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>		DATE SIGNED <u>4/18/60</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

42.

1  
FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

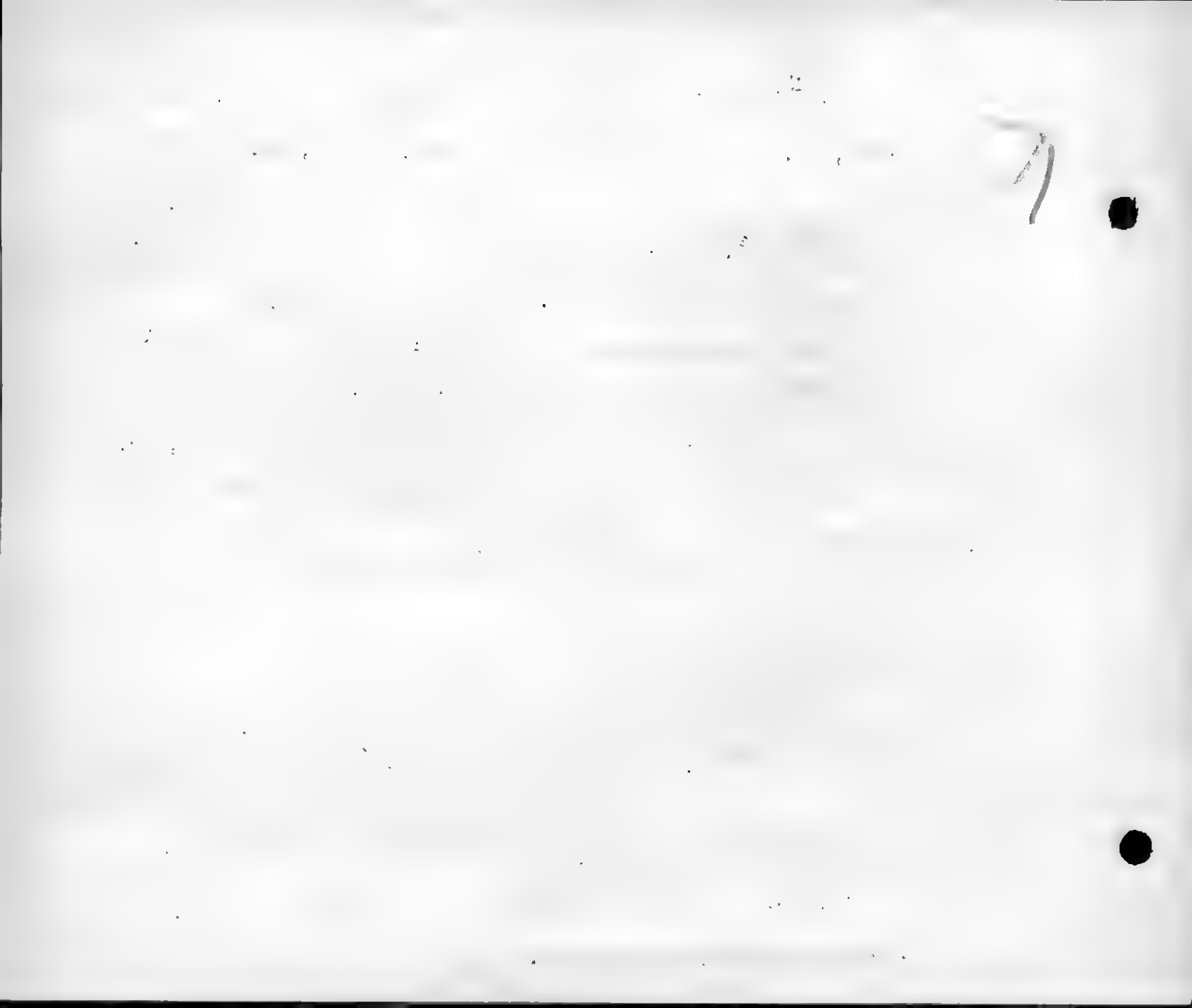
MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
7240 07256									
1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>Week on arrival</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u> d. STREET ADDRESS <u>6321 Central Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>EARL WILSON RANDALL</u>					4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Sept. 25, 1930</u>				
9. AGE (In years last birthday) <u>29</u> yrs.					10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.				
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>William Franklin Randall</u>					14. MOTHER'S MAIDEN NAME <u>Thelma Thane</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>578-36-4404</u>				
17. INFORMANT <u>June Randall, Father on on</u>					Address <u>Far down road</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Crushed skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a), 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Occupant of auto that ran broadside into</u>				
20c. TIME OF INJURY Month, Day, Year <u>6-3-1960</u>					20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Country</u>					20f. (City or town) <u>Forestville</u> (County) <u>Pr</u> (State) <u>MD</u>				
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James I. Boyd</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M. D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>June 6, 1960</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>					22d. LOCATION (City, town, or country) <u>Bladensburg, Maryland</u> (State)				
23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO.,</u>					ADDRESS <u>Riverdale, Maryland.</u>				
24a. REC'D BY REGISTRAR <u>JUN 8 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>				

2

# 7192 CERTIFICATE OF DEATH

Reg. Dist. No. 07257

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md.</b>		c. LENGTH OF STAY IN Tb <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4331 Rowalt Drive</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>71 College Park, Md.</b>	
f. STREET ADDRESS <b>14231 Rowalt Dr</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis Marion Ray</b>		4. DATE OF DEATH <b>June 22 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 19-1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printer and Publisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tennessee</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>D B Ray</b>		14. MOTHER'S MAIDEN NAME <b>Marion James</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Elizabeth M Ray</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Acute Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Failure</b> DUE TO <b>Extensive-sclerotic Heart Dis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 Min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> , 19 to <b>June 1960</b> , that I last saw the deceased alive on <b>June 8 1960</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4713 Sterling Rd e/24/60</b> ACTUAL SIGNATURE <b>W. C. Etienne</b> M.D. PHYSICIAN'S NAME (Type) <b>W. C. ETIENNE College Park Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7260

## CERTIFICATE OF DEATH

07258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> c. LENGTH OF STAY IN 1b <b>Laurel General Hospital</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b> d. STREET ADDRESS <b>Pox 261</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise Redmiles</b>				4. DATE OF DEATH Month Day Year <b>June 19 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1909</b>	
9. AGE (In years last birthday) <b>50</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hugh Barton</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Harrington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>not</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO <b>pelvic Abscess</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post-operative - Total hysterectomy</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>48 hrs</b> <b>48 hrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/11</b> 19 <b>60</b> , to <b>6/19</b> 19 <b>60</b> , that I last saw the deceased alive on <b>6/19/60</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>150 Wash Blvd</b> DATE SIGNED <b>6/21/60</b>							
ACTUAL SIGNATURE <b>Joseph B. Sindelar</b> M.D. <b>150 Wash Blvd</b>							
PHYSICIAN'S NAME (Type) <b>Joseph B. Sindelar, M.D., 150 Washington Blvd., Laurel, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>6/22/60</b>		<b>Any Hill Cem.</b>		<b>Laurel, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. Witt Donaldson</b>				24a. REC'D BY REGISTRAR <b>JUN 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 07259

7241

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>	
c. LENGTH OF STAY IN 1b <b>8 hrs</b>		d. STREET ADDRESS <b>Rt. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Irving</b> Middle <b>Riggs</b> Last <b>Riggs</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Feb 1905</b>
9 AGE (In years last birthday) <b>55</b> yrs		IF UNDER 1 YEAR Months <b>55</b> Days <b>13</b> Hours <b>19</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wesley Riggs</b>		14. MOTHER'S MAIDEN NAME <b>Louise Creek</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>Matilda Riggs</b> Address <b>Lothian Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>Final diagnosis deferred pending microscopic examination.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>microscopic examination.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>60</b> , to <b>June 13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 12</b> , 19 <b>60</b> , and that death occurred at <b>6,25 AM</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED <b>6-12-60</b>	
ACTUAL SIGNATURE <b>Wesley Riggs</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL. (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moses Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Anne Arundel County, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.K. Stewart</b>		24a. REC'D BY REGISTRAR <b>JUN 15 '60</b>	
ADDRESS <b>30 H Street, N.E. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7242

## CERTIFICATE OF DEATH

07260

Reg. Dist. No.

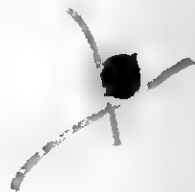
1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baldensburg</b>			
f. STREET ADDRESS <b>4204 53 rd Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Carolyn</b> Middle <b>Roberts</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1960</b>			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>18 Dec. 1873</b>	
9 AGE (In years last birthday) <b>86</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min		11 BIRTHPLACE (State or foreign country) <b>New York</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13. FATHER'S NAME <b>Eugene Elberts</b>				14. MOTHER'S MAIDEN NAME <b>Janet Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Wm W Roberts</b>				Address <b>Bladensburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro intestinal Bleeding-fection undetermined</b> DUE TO <b>2-3 hours</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Insufficiency</b>							
20a. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>6-9</b> , 19 <b>60</b> , to <b>6-10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-10</b> , 19 <b>60</b> , and that death occurred <b>5:18 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Perry St</b> DATE SIGNED <b>June 10-1960</b>							
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>				M.D. <b>3503 Perry St</b>			
PHYSICIAN'S NAME (Type) <b>Dr. W.B. Moyers MD.</b>				Mt. Rainier., Md			
22a. BURIAL CREMATION, REBURY (State)		22b. DATE THEREOF <b>Burial June 14, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Barnabas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leeland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Gasch's Sons Hyattsville, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

Page 4

VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, the funeral director, should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

551



7261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN 1b <b>adm 6-16-1960</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY EMMA ROYER</b>		4. DATE OF DEATH <b>6 19 1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>2 18 65</b>
9. AGE (In years last birthday) <b>95</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GEORGE TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET LONG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac fibrillation (433.1)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease (422.1)</b> DUE TO (c) <b>1953</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smoking</b> (b) <b>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-16-</b> 19 <b>60</b> to <b>6-19-</b> 19 <b>60</b> that I last saw the deceased alive on <b>6-19-</b> 19 <b>60</b> , and that death occurred at <b>2:45</b> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Erika P. Kraemer</b> M.D.		ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM 6-19-60</b>	
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		<b>LAUREL MARYLAND</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Centerville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Batten Jr.</b>		ADDRESS <b>of Batten Bros. Centerville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7193

## CERTIFICATE OF DEATH

Reg. Dist. No.

07262

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8704 Baltimore ave		d. STREET ADDRESS 18704 Baltimore avenue	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH HUNTER ROSE		4. DATE OF DEATH Month Day Year June 3, 1960 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 17, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Matiance		10b. KIND OF BUSINESS OR INDUSTRY Real Estate co	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph H. Rose		14. MOTHER'S MAIDEN NAME Caroline Greenlaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary C Rose		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular disease generalized</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Typhlocystitis</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-12, 1959, to 5-17, 1960, that I last saw the deceased alive on 5-17, 1960, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>D. R. Purdie</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4404 2nd St. Riverdale, Md.	
PHYSICIAN'S NAME (Type) D. R. Purdie		Riverdale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7198

## CERTIFICATE OF DEATH

Reg. Dis. No. 07263

1 PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>65 Riverdale, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor, 4922 LaSalle Rd.</u>		1 d STREET ADDRESS <u>6111 Baltimore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Sanders</u> Last <u>Sanders</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1960</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-1869</u>
9 AGE (In years last birthday) <u>90 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Siggamala, Sweden</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Carl Bengtson</u>		14. MOTHER'S MAIDEN NAME <u>Christine Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1-62 Pulmonary Infarction</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Phlebotrombosis</u> DUE TO (c) <u>Post operative thigh amputation 6 wks</u>		INTERVAL BETWEEN ONSET OF DEATH <u>6 hrs.</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility Decubiti</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>present</u> , that I last saw the deceased alive on <u>6 June</u> , 19 <u>60</u> , and that death occurred at <u>6:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Bayly</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1835 Eye N.W. 6 June 60</u>	
PHYSICIAN'S NAME (Type) <u>John H. Bayly</u>		<u>WASH. D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7243

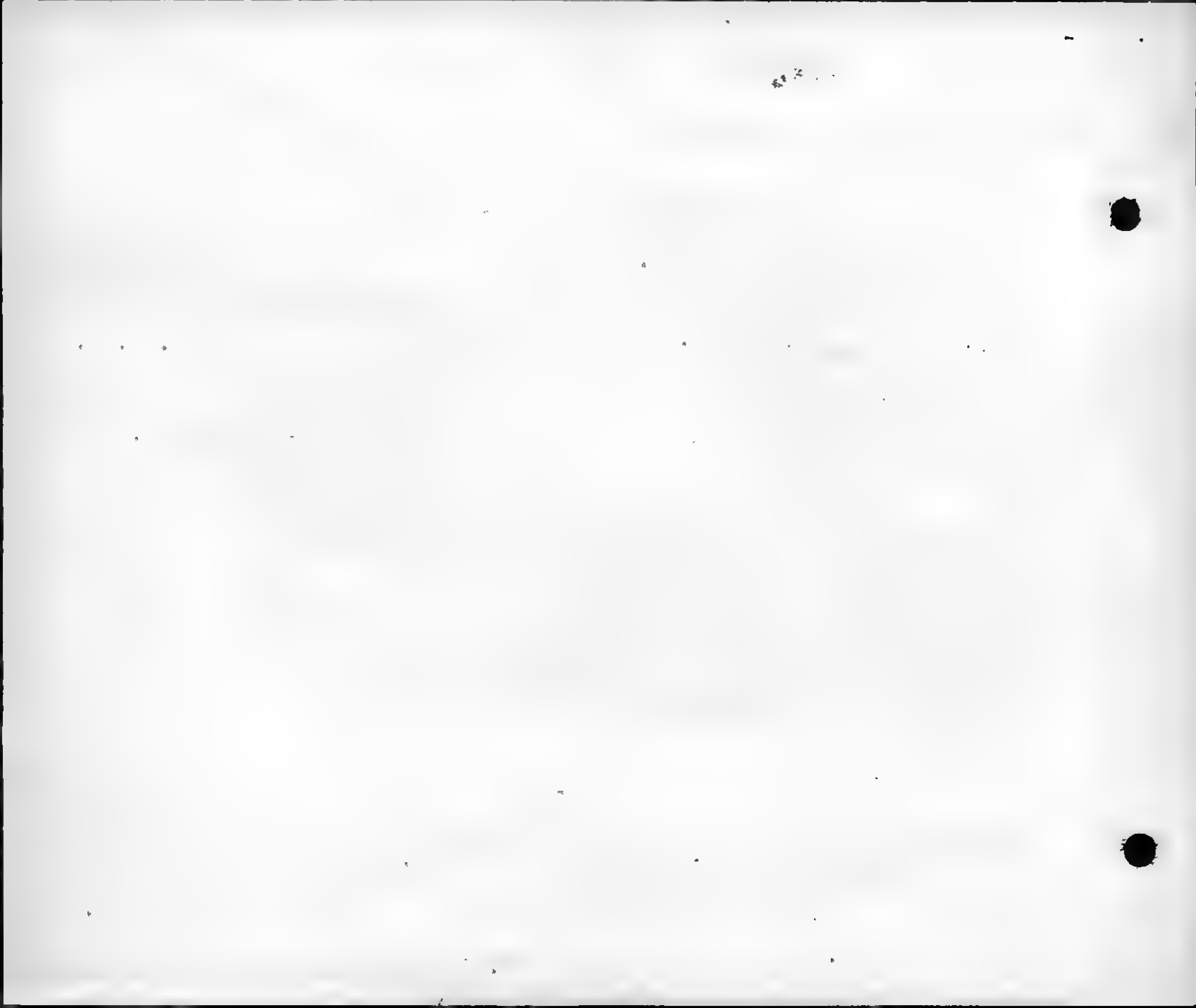
## CERTIFICATE OF DEATH

Reg. Dist. No. 07264

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>G.</u> Last <u>SASSCER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor of Medicine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Practice (Own)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Sasscer</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Claggett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Rosalie Sasscer-Same as Item 2.</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>60</u> to <u>6/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>60</u> , and that death occurred at <u>10:57</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>6/15/60</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat Comeau</u>		<u>MT Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/58ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

07265

7299

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS, RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>			
c. LENGTH OF STAY IN lb <u>31 DAYS</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL Andrews</u>				d. STREET ADDRESS <u>3801 24th St N</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES</u> <u>FREDERICK</u> <u>SETCHELL</u>				4. DATE OF DEATH Month Day Year <u>JUNE</u> <u>13</u> <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 AUG 1913</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USAF RET</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ILLINOIS</u>			
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>FREDERICK J. SETCHELL</u>				14. MOTHER'S MAIDEN NAME <u>WINIFRED Noble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES</u> <u>1938-1960</u>				16. SOCIAL SECURITY NO. <u>339-01-7235</u>			
INFORMANT <u>WIFE</u>				Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROBABLE INTERCURRENT INFECTION</u> <u>193.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASTROCYTOMA Grade IV, recurrent</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>13 June</u> , 19 <u>60</u> , to <u>13 June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>13 JUNE</u> , 19 <u>60</u> , and that death occurred at <u>4:54 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAF HOSPITAL ANDREWS</u> <u>13 JUNE 1960</u> ACTUAL SIGNATURE <u>Andrew W. Butchko</u> M.D. PHYSICIAN'S NAME (Type) <u>ANDREW W BUTCHKO, Capt, USAF MC</u> <u>ANDREWS AFB WASHINGTON 25, D.C.</u>							
22a. BURIAL, CREMAT. OR REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 17, 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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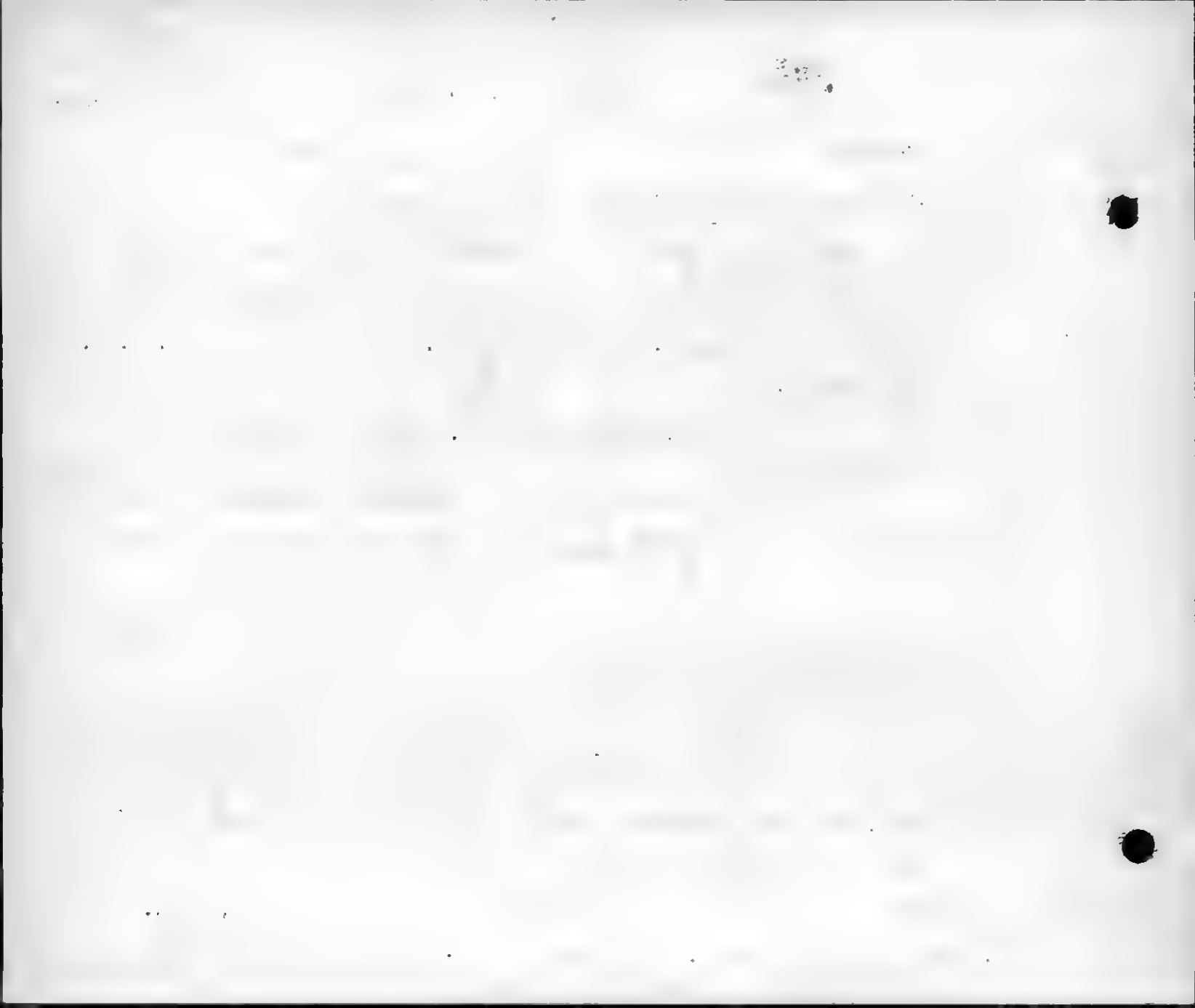
## CERTIFICATE OF DEATH

Reg. Dist. No. 07266

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>3614 Newark Road</b>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Jacob</b> Middle <b>Simpson</b> Last		4. DATE OF DEATH <b>June</b> Month <b>29</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 25, 1901</b>
9. AGE (In years lost birthday) <b>59</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Const. Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Simpson</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>161-12-0959</b>	
17. INFORMANT <b>Jessie M. Simpson</b>		Address <b>(same as # 2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hyper sensitive cardiac muscular disease</b> DUE TO (c) <b>Atrial fibrillation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-27-60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-27</b> , 19 <b>60</b> , to <b>6-29</b> , 19 <b>60</b> that I last saw the deceased alive on <b>6-29</b> , 19 <b>60</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Hageage M.D.</b>		ADDRESS (Street, city or town, state) <b>3717-38th Ave</b>	
PHYSICIAN'S NAME (Type) <b>Geo. J. Hageage</b>		DATE SIGNED <b>6-30-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln</b>		22d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>4739 Balt. Ave, Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be read by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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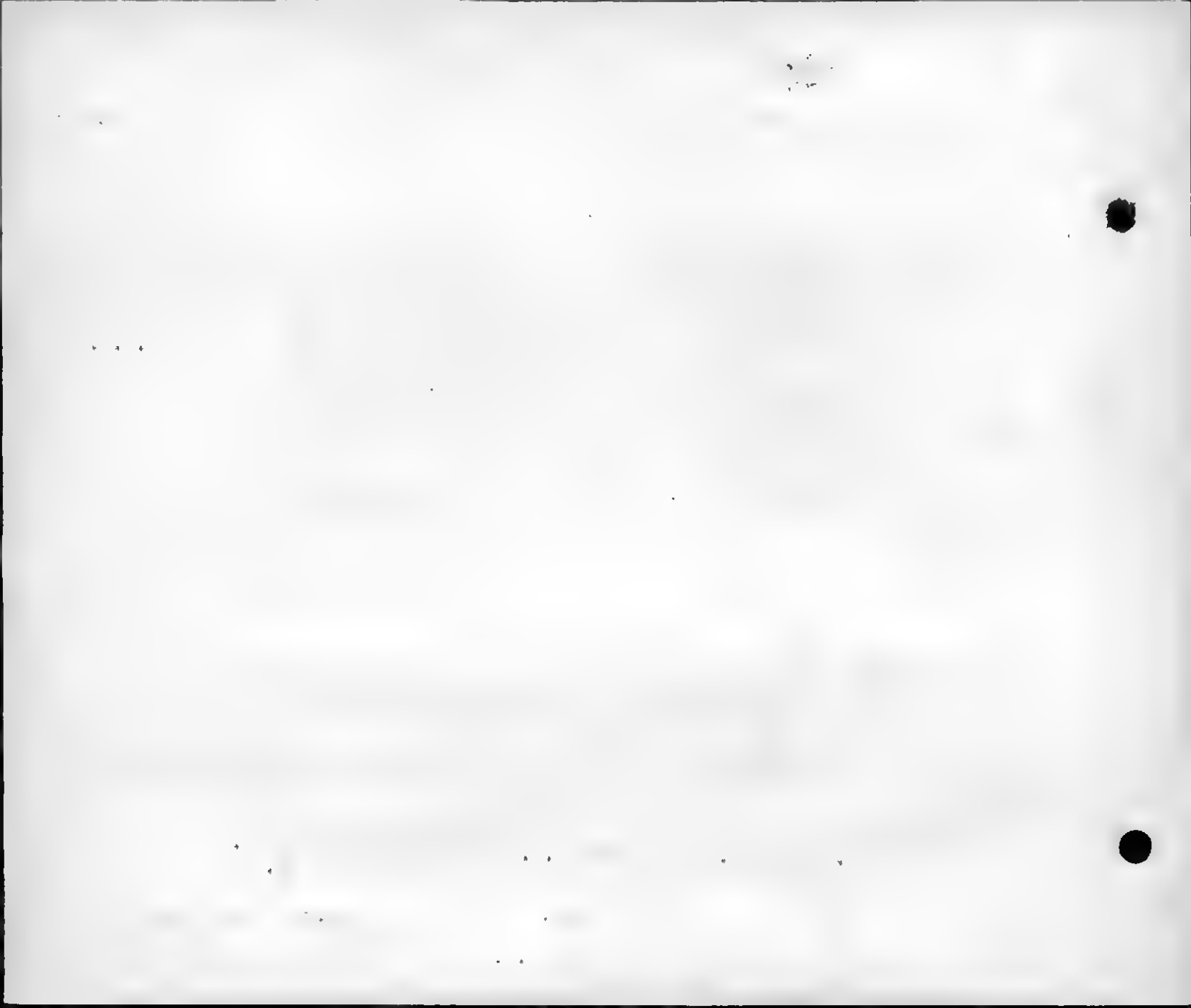
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07267

7245

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>Rt 3 Box 347</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Smith</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/16/60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>12</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Oswald Smith</b>		14. MOTHER'S MAIDEN NAME <b>Eunice Oswald Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <b>Mother</b> Address <b>Same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>771.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asphyxia</b> (c) <b>Terminal multiple lower lobe</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. m.</b> Month, Day, Year <b>19 60</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1960</b> , to <b>June 27, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 27, 1960</b> , and that death occurred at <b>6:10 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Christensen</b> M.D.		22b. DATE <b>6/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen, M.D.</b>		22d. ADDRESS <b>6905 Baltimore Ave., College Park Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/30/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gibbons Meth. Church</b>	23d. LOCATION (City, town, or county) (State) <b>Brandywine, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Stewart</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 1 '60</b>	
ADDRESS <b>30 H Street, N.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Stewart</b>	

2077281XV2



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

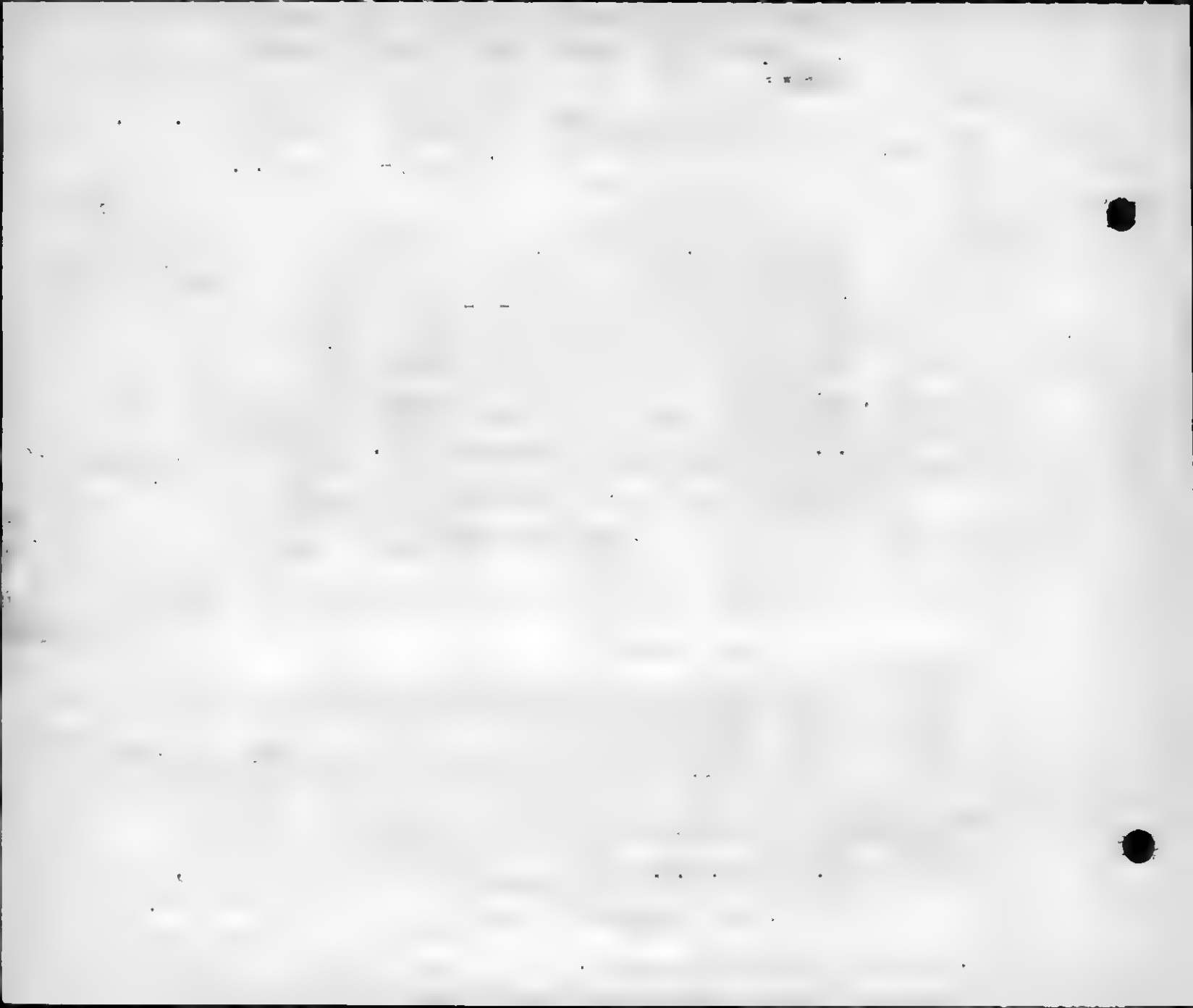
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07268**

7246

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Piscatoway- Clinton P.O.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>William</b> Last <b>Smith</b> S.R.			4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-26-1908</b>		9. AGE (In years last birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles S. Smith</b>			14. MOTHER'S MAIDEN NAME <b>Alberta Goshorn</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>W.W.2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Smith, Jr.</b> Address <b>826 50th Avenue</b> <b>Capitol Heights, Washington-27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Acute congestive heart failure</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b></p> <p>(c)</p> </div> <div style="width: 65%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
<b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>June 13, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1960</b>		22c. NAME OF CEMETERY OR <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Arlington Virginia.</b>		22e. (State) <b>Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '60</b>
			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar for burial-cremation, or removal.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
See Birth Cert. 27  
**CERTIFICATE OF DEATH**

07269

Reg. Dist. No.

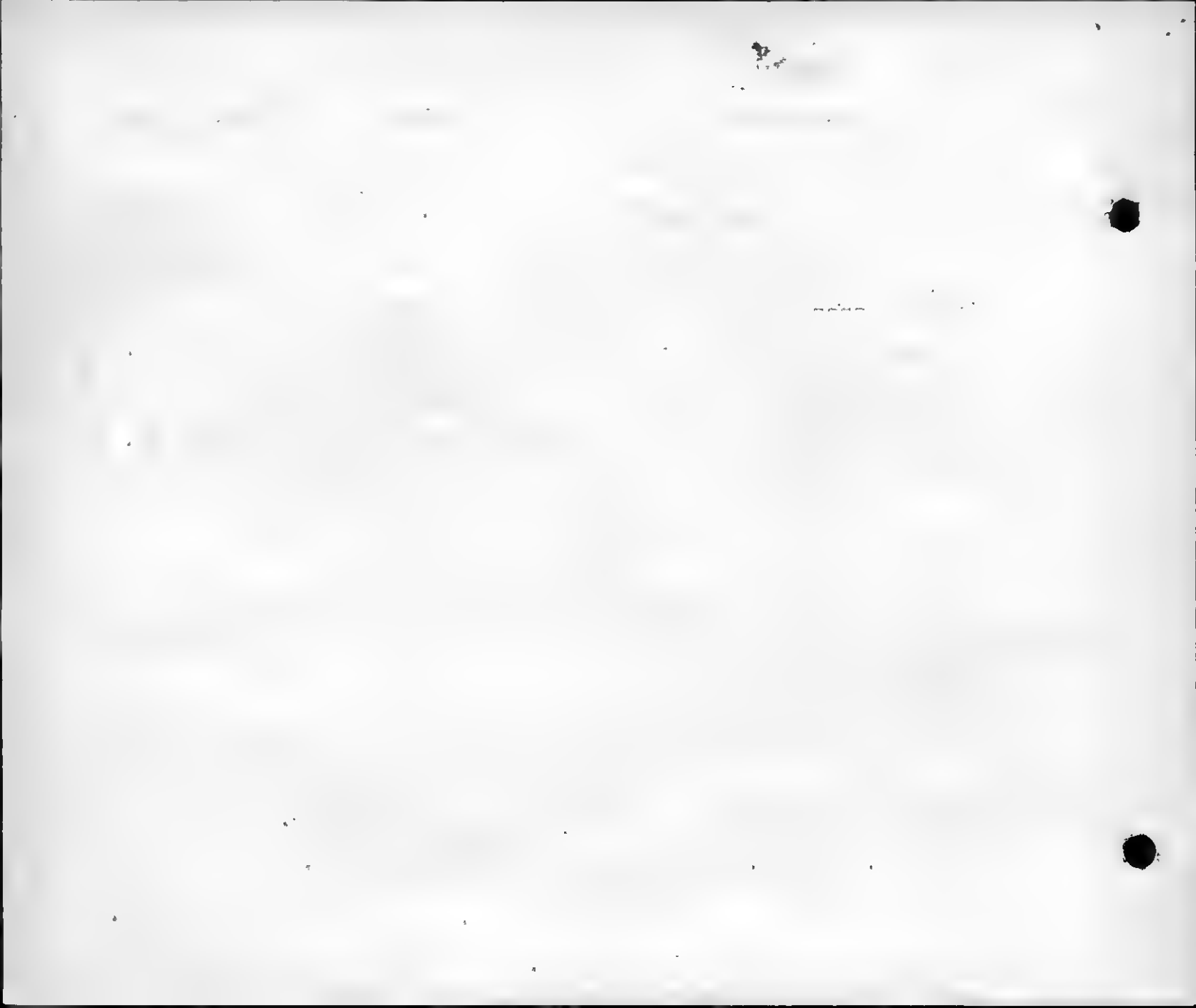
**7247**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>13 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Rt. 2 Box 2261</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) <b>Baby Girl Spriggs</b>		<b>4 DATE OF DEATH</b> Month <b>June</b> Day <b>12</b> Year <b>19 60</b>		<b>5 SEX</b> <b>Female</b> <b>6 COLOR OR RACE</b> <b>Negro Black</b> <b>7 MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8 DATE OF BIRTH</b> <b>11 June 1960</b>		<b>9 AGE</b> (In years last birthday) <b>13</b> <b>10a USUA. OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>---</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>Melvin Spriggs</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Gwyneth Savoy</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>---</b> <b>INFORMANT</b> <b>Melvin Spriggs-Same as Item #2.</b> Address		<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congenital heart disease</b> DUE TO (b) <b>atelectasis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			
<b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____		<b>20c TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____		<b>21. I certify that I attended the deceased from</b> <b>June 11</b> , 19 <b>60</b> , to <b>June 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 11</b> , 19 <b>60</b> , and that death occurred at <b>12:40A</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>6905 Baltimore Ave.</b> <b>DATE SIGNED</b> <b>6/12/60</b> <b>ACTUAL SIGNATURE</b> <b>Thomas A. Christensen M.D.</b> <b>PHYSICIAN'S NAME (Type)</b> <b>Dr. Thomas A. Christensen</b> <b>College Park, Md.</b>			
<b>22a BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b DATE THEREOF</b> <b>6/14/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Family Cath. Cem.</b> <b>Woodmore Md.</b>			
<b>22d. LOCATION</b> (City, town, or county) _____ (State) _____		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUN 22 '60</b> <b>DATE</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be attached to page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the attending physician and completely filled out by the funeral director. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07270

7300

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Gea</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2817-Colebrook Dr. SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Stahl</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6 - 1875</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Stahl</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Weaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Goldie Walker</u>	
17. INFORMANT <u>Goldie Walker</u>		Address <u>2817-Colebrook Dr. Hillcrest Hgts</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive right pleural effusion</u> DUE TO (c) <u>Pulmonary infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>2 weeks</u> <u>3 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>60</u> , to <u>6-2</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-1</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>David S. Gordon</u> , M.D.		ADDRESS (Street, city or town, state) <u>5731 23rd Avenue SE</u> DATE SIGNED <u>6-2-60</u>	
PHYSICIAN'S NAME (Type) <u>David S. Gordon</u>		<u>Woods 21, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-2-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Pleasant Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samson Bros</u>		ADDRESS <u>1661-Good Hope Rd SE</u>	
24a. REC'D BY REGISTRAR <u>Wash 20 DC</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis L. Hume</u>	





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove the page from the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

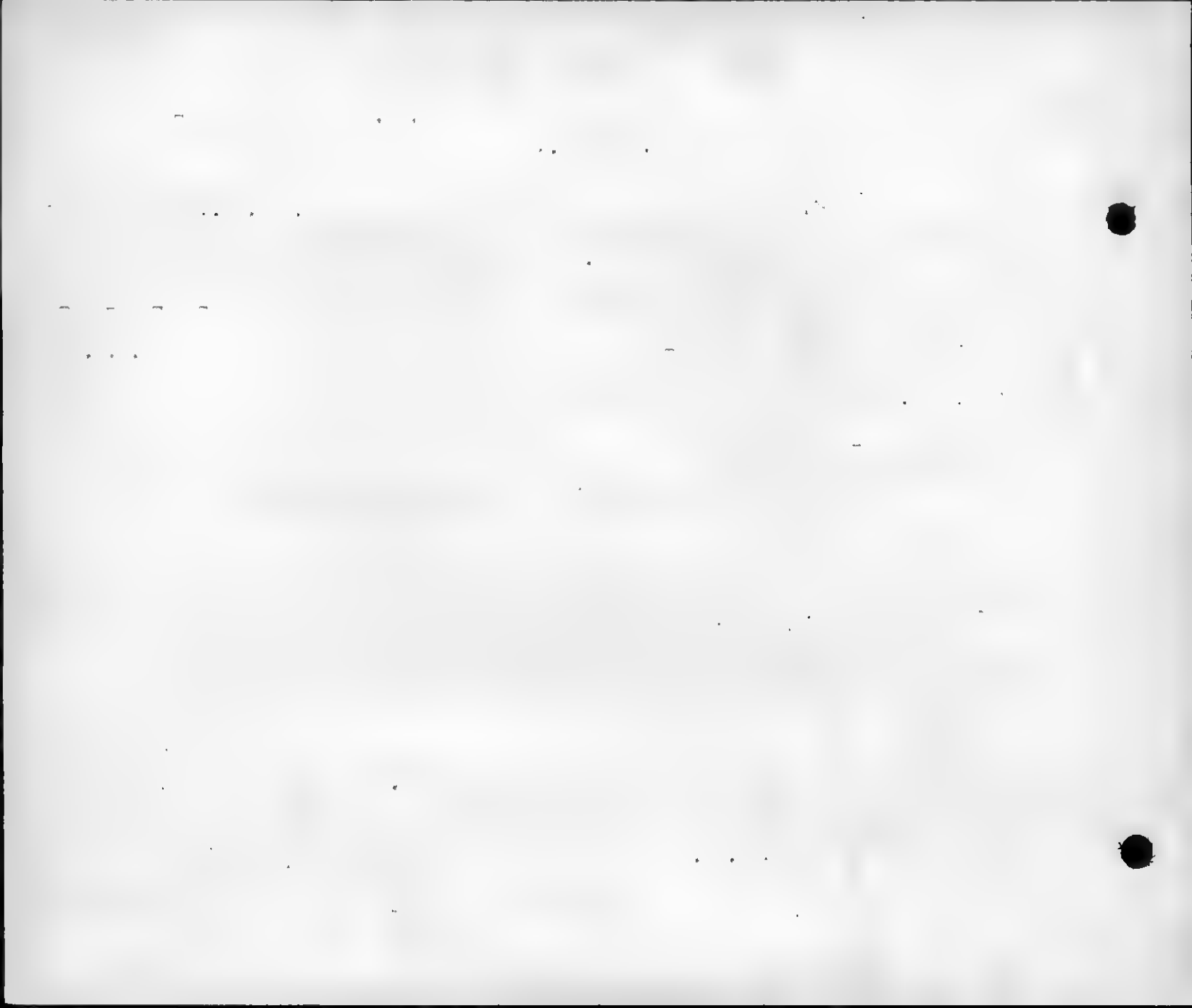
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07271

7301

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1722 Bay St., S. E., Apt 2</b>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>B.</b> Last <b>Stubblefield</b>				4. DATE OF DEATH Month <b>6</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/82</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR: Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>-</b> IF UNDER 24 HRS: Hours <b>-</b> Min <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown (unemployed)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Tenley</b>				14. MOTHER'S MAIDEN NAME <b>Liza Wheat</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease with auricular fibrillation, decompensated</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis, far advanced, active (18 months) Unimproved (Chemotherapy) died; pulmonary emphysema; pulmonary edema</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/2</b> <b>1959</b> to <b>6/6/</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>6/6/</b> <b>1960</b> , and that death occurred at <b>2:00</b> <b>A.</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Moe Weiss</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/6/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial June 8-60</b>		23b. DATE THEREOF <b>June 8-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Seinthland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>				ADDRESS <b>1661- Good Hope Rd</b>		25. REC'D BY REGISTRAR <b>SUN 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

last no 22 SE



## CERTIFICATE OF DEATH

Reg. Dist. No.

072722

7302

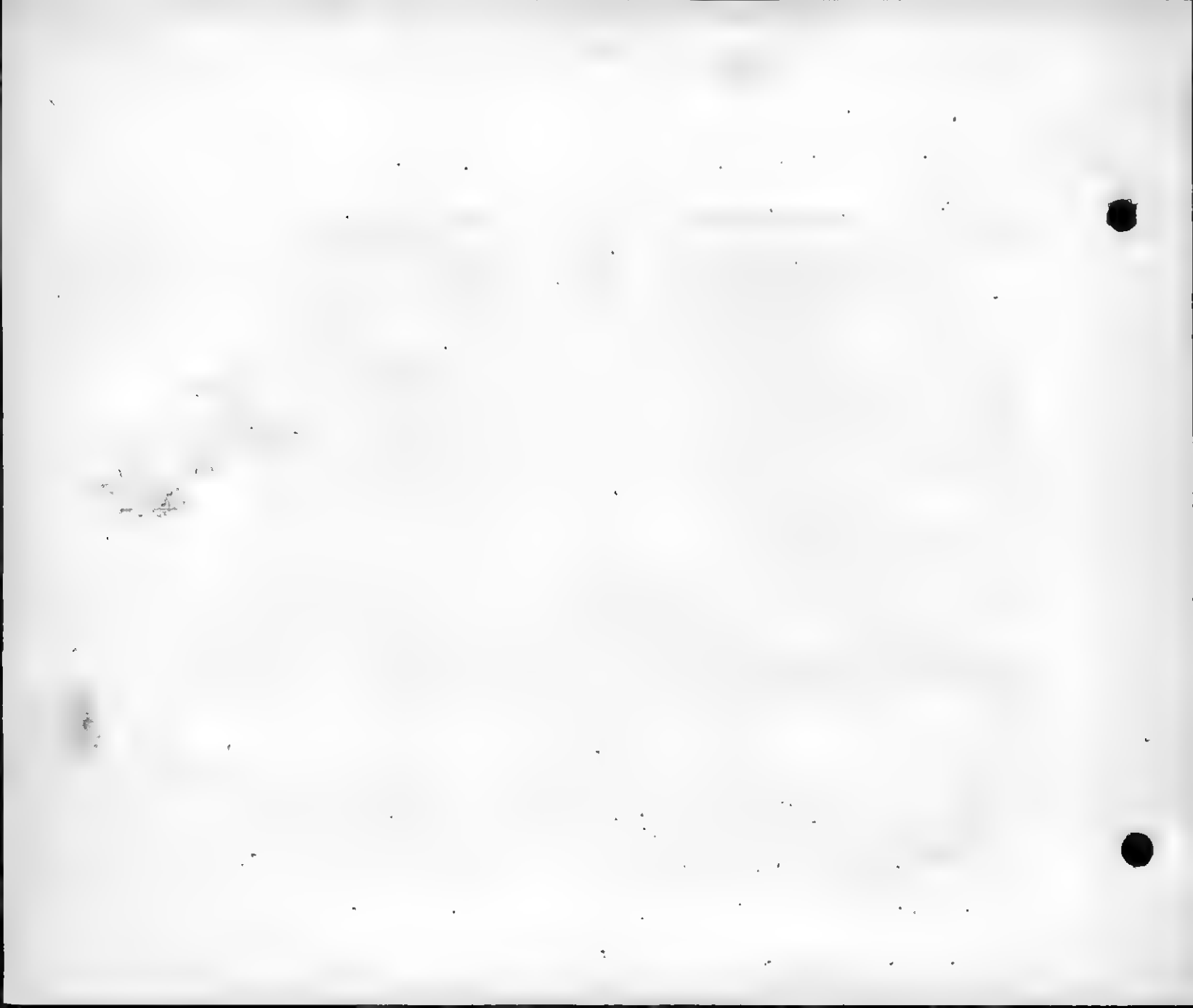
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>18 DAYS</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS, WASH 25 DC</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>4287 6th ST SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KAREN</b> Middle <b>SUE</b> Last <b>SUTTON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 MAY 1960</b>
9. AGE (In years last birthday) yrs. <b>13</b>		IF UNDER 1 YEAR Months <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JAMES E SUTTON</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA J HALLETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT <b>FATHER</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>204.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b> <b>17 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>27 May</b> , 19 <b>60</b> , to <b>14 June</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>14 June</b> , 19 <b>60</b> , and that death occurred at <b>1025 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>USAF HOSPITAL ANDREWS</b> <b>14 JUNE 60</b>			
ACTUAL SIGNATURE <b>John A. Moore</b>		M.D. <b>USAF HOSPITAL ANDREWS</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A MOORE, MAJOR USAF (MC)</b>		<b>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 17, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Russell Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '60</b>	
ADDRESS <b>816 H St. N.E. Wash DC</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

2050234XV4



7303

## CERTIFICATE OF DEATH

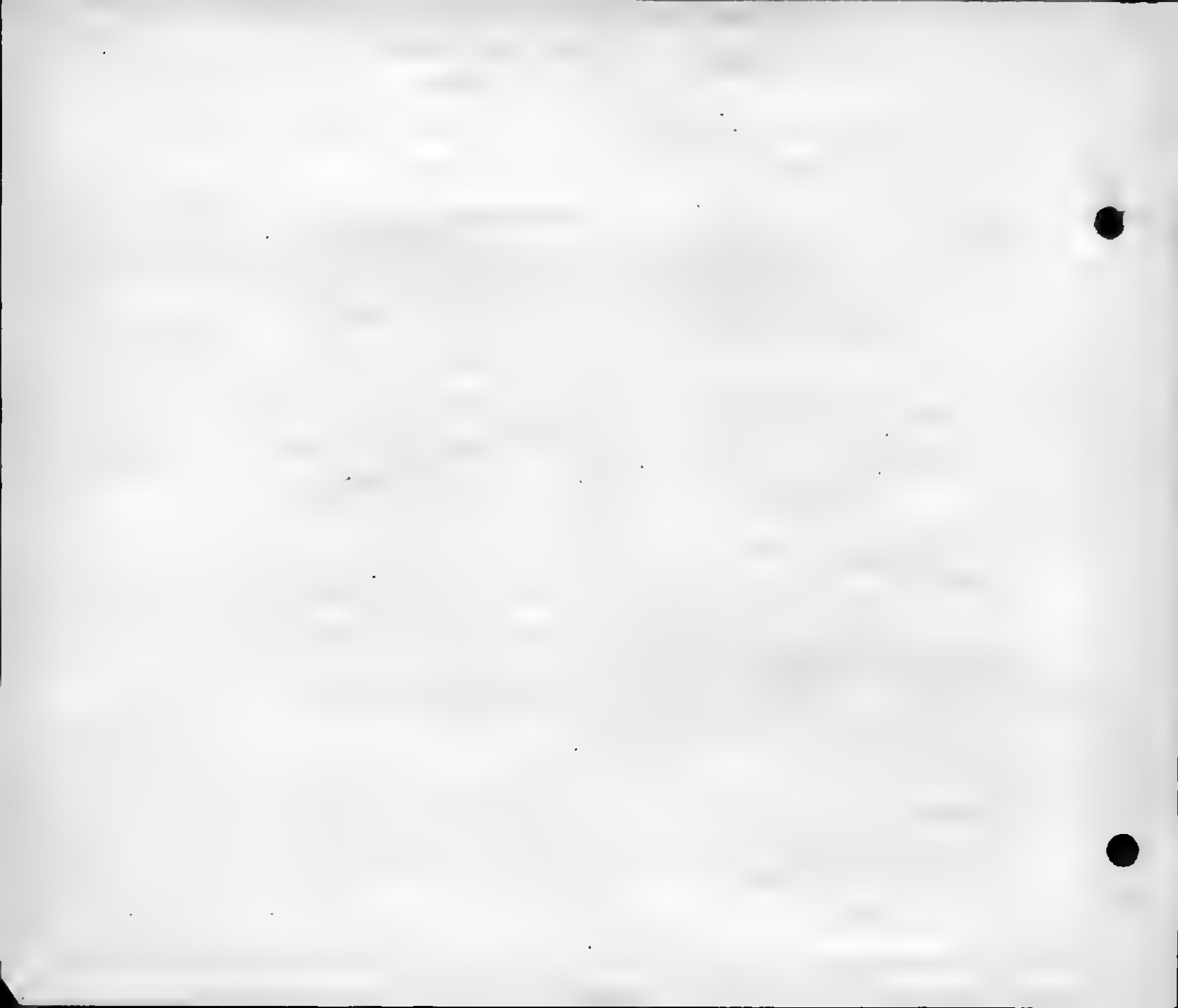
07273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7255 E. FORT FORT TERRY</u>		d. STREET ADDRESS <u>7255 E. FORT FORT TERRY</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ISABEL</u> Last <u>SWANDELLS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7 1899</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES C. BURY</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. KELLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ANNIE K. ARMSTRONG</u>		Address <u>7255 E. FORT FORT TERRY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC DECOMPRESSION</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 14, 1960</u> , to <u>JUNE 29, 1960</u> , that I last saw the deceased alive on <u>JUNE 29, 1960</u> , and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent J. DiZack</u> M.D.		ADDRESS (Street, city or town, state) <u>2430 E. FORT TERRY</u> DATE SIGNED <u>JUNE 29, 1960</u>	
PHYSICIAN'S NAME (Type) <u>VINCENT J. DiZACK</u>		<u>WASH D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 1st - 60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		ADDRESS <u>1661 9th Hope Rd</u>	
24a. REC'D BY REGISTRAR <u>Wash DC</u>		24b. REGISTRAR'S SIGNATURE <u>Wm S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# STATE OF MARYLAND—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07274

Reg. Dist. No. 07274

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Park</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Henry</u> Last <u>TASS</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1939</u>
9. AGE (in years last birthday) <u>20 yrs.</u>		IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>20</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ex-Airman 2d class</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry J. Tass</u>		14. MOTHER'S MAIDEN NAME <u>Minerva E. Cahill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>579-50-3272</u>	
17. INFORMANT <u>Mrs. Minerva E. Tass</u>		Address <u>4670 Homer Ave., Suitland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>173.1</u> DUE TO <u>asphyxia</u> Conditions, if any, which gave rise to immediate cause (b) <u>acute carbon monoxide poisoning</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Ran here from exhaust into car</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 9, 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Park Ave</u>	20f. (City or town) <u>Suitland</u> (County) <u>PG</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES J. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia.</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u>		24a. REC'D BY REGISTRAR <u>JUN 13 '60</u> DATE	
ADDRESS <u>Riverdale, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give flags 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use.

28



7248

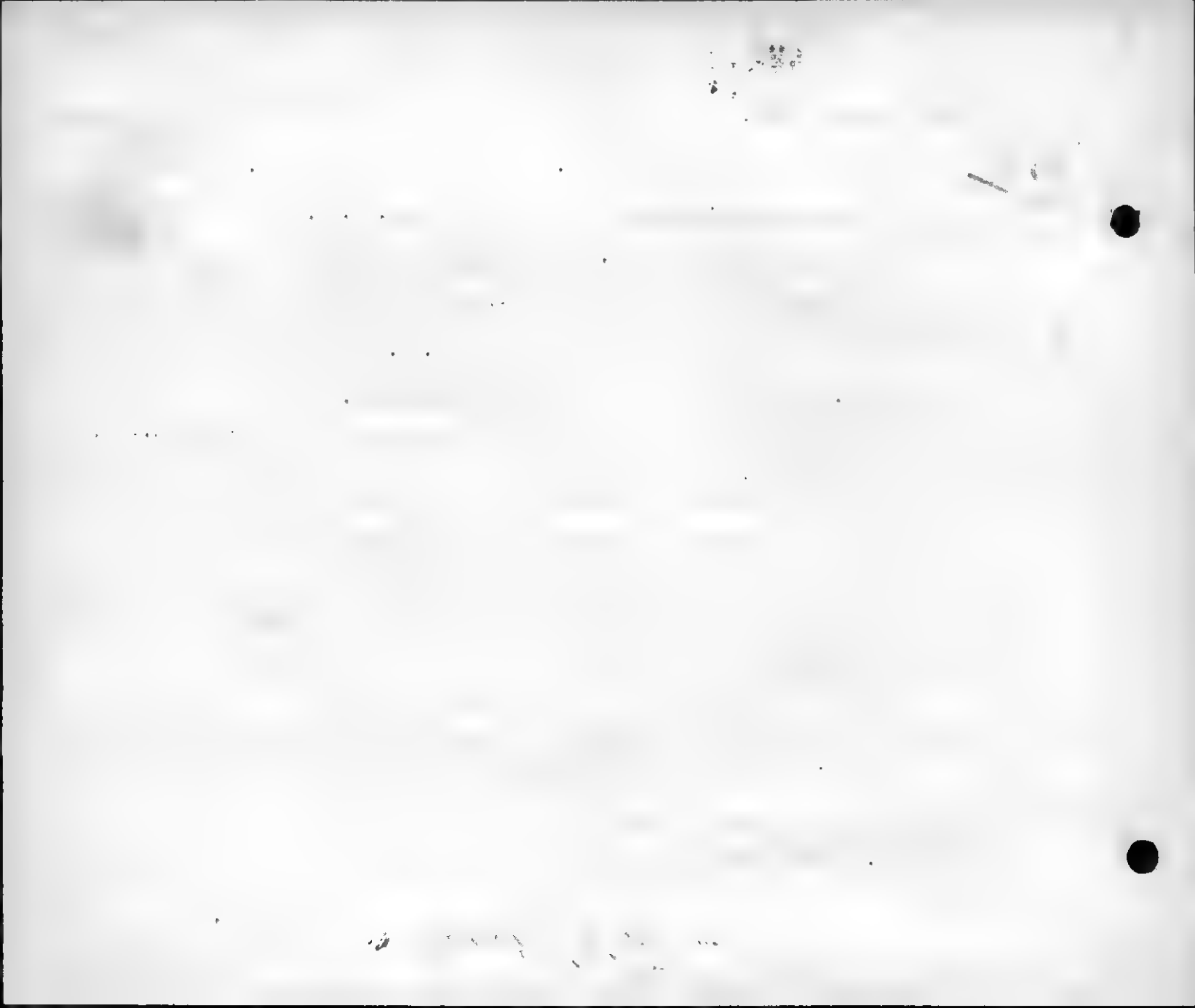
CERTIFICATE OF DEATH

07275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>6 days 3 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>R.</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-28-93</u>	
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert R. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Elizabeth Notestine</u> Address <u>4804 V St., SE</u> <u>Wash 27 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Glor and nephritis</u> DUE TO <u></u> (c) <u></u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>							
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>60</u> to <u>June 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>60</u> , and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>3717-38th Ave Cottage City Md</u> DATE SIGNED <u>6-12-60</u>							
ACTUAL SIGNATURE <u>George Hageage</u> M.D. <u>3717-38th Ave Cottage City Md</u>							
PHYSICIAN'S NAME (Type) <u>Dr. George Hageage</u> <u>3717-38th Ave Cottage City Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bus Wash. D.C.</u> ADDRESS <u>1661 14th St NW Wash. D.C.</u> NO. REC'D BY REGISTRAR <u>JUN 14 60</u> DATE <u></u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



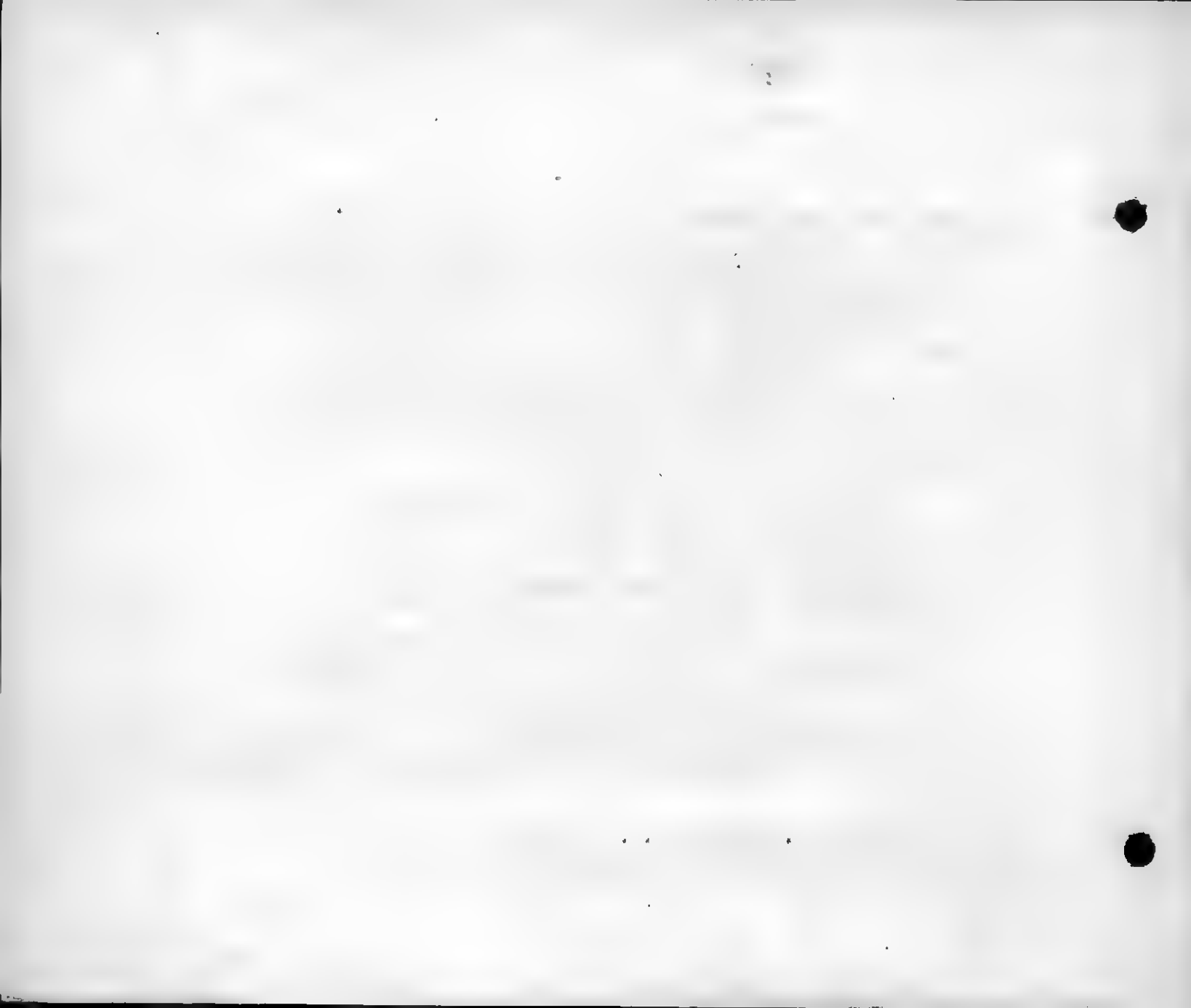
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07276

7249

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Thomas</b> Last <b>Laurel</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 May 1968</b>	
9. AGE (in years last birthday) <b>92</b> yrs		IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>19</b> Min.		IF UNDER 24 HRS Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joshua Bacon</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Bacon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <b>Adrenal Failure</b>							
DUE TO (b) <b>Pelvic Abscess</b>							
DUE TO (c) <b>Perforated Appendix</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 19</b> , 19 <b>60</b> to <b>JUNE 26</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>June 26</b> , 19 <b>60</b> , and that death occurred on <b>7, 35 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dayton O. Watkins</b>				22b. DATE, TIME, AND SIGNATURE <b>6/26/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>DAYTON O. WATKINS</b>				22d. ADDRESS <b>5304 Annapolis Rd. Bladensburg Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>6/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>		23d. LOCATION (City, town, or county) (State) <b>Harman Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				25a. REC'D BY REGISTRAR <b>Rockville, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



7255

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			c. LENGTH OF STAY IN 1b 10 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Colmar Manor		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4101 Newton Street				d. STREET ADDRESS 4101 Newton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mittie Rachel Tucker				4. DATE OF DEATH Month Day Year June 11, 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1885		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin F. Shipley				14. MOTHER'S MAIDEN NAME Mary Elizabeth Mulleneaux			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Julia C. Williams		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis</i> <i>150.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1, 1959</i> to <i>June 11, 1960</i> , that I last saw the deceased alive on <i>June 3, 1960</i> , and that death occurred at <i>11:45</i> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <i>Belmeade Md June 11-1960</i>							
ACTUAL SIGNATURE <i>C. D. Connor</i> M.D.				PHYSICIAN'S NAME (Type) <i>C. D. CONNOR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6/14/60</i>		<i>Maple Lawn</i>		<i>Forestboro Tennessee</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gracie sons Hyattsville Md</i>				24a. RECEIVED BY REGISTRAR DATE <i>JUN 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44

7250

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2days</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		d. STREET ADDRESS <b>5457 Madison Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>JAMES ARCHIE UNDERWOOD</b>		4. DATE OF DEATH Month Day Year <b>6 2 1960</b>		5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-22-83</b>		9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired D C Gov't</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School custodian</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Thomas Underwood</b>		14. MOTHER'S MAIDEN NAME <b>Anna Munk</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>John W Underwood</b>		Address <b>Cheverly Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>570.3 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Sanguine of the small intestine</b> (c) <b>Water ulcer of the small intestine</b>		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2-19</b> , 19 <b>59</b> , to <b>6-2</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-1</b> , 19 <b>60</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>513 Paulding Rd</b>		DATE SIGNED <b>1-1</b>		ACTUAL SIGNATURE <b>R.D. BAKER</b>		PHYSICIAN'S NAME (Type) <b>R.D. BAKER M.D.</b>		22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>											

14.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

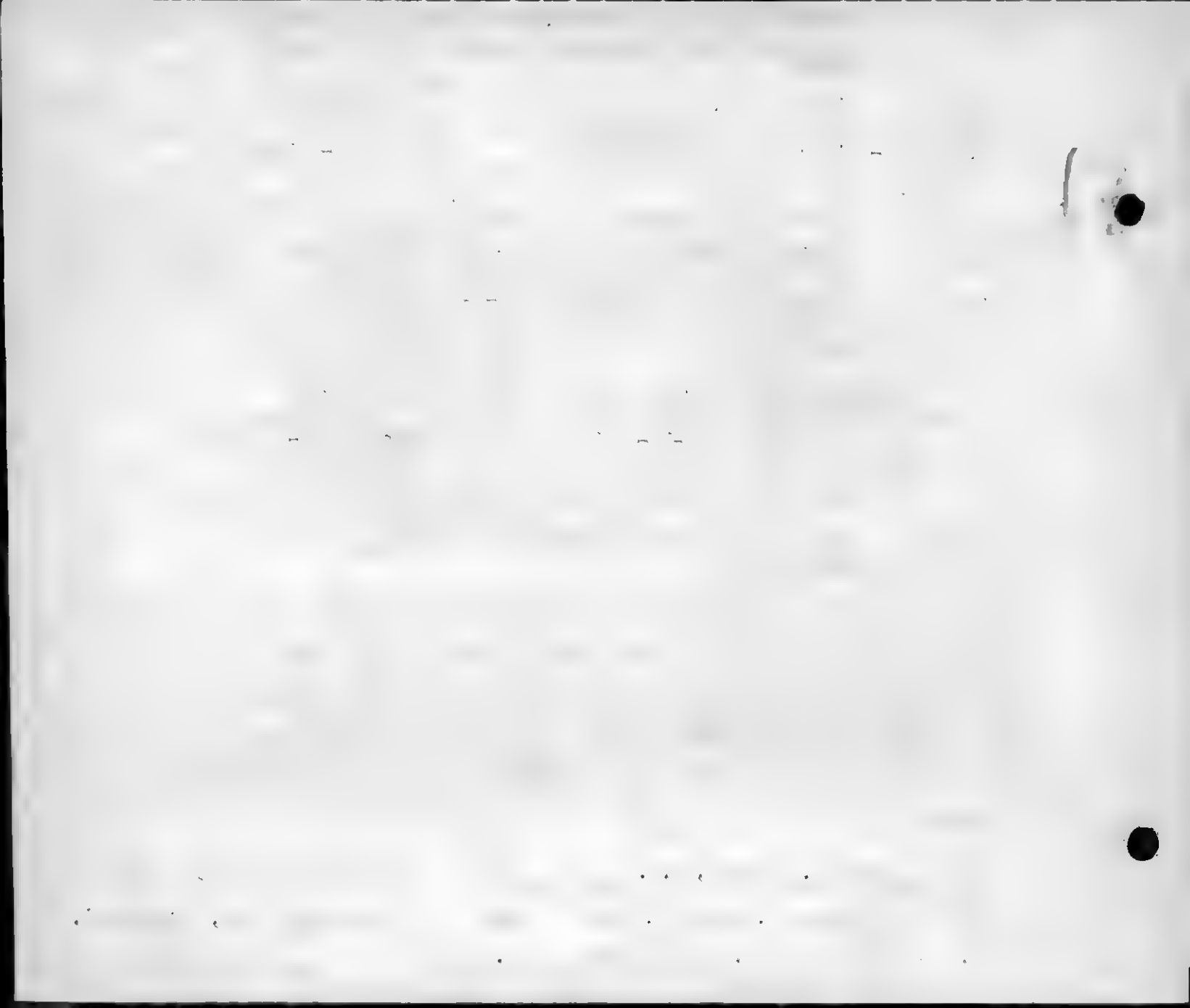
## 2267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07279

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Pines- Riverdale</b>		c. LENGTH OF STAY IN 1b <b>14 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5703 64th Avenue</b>		e. STREET ADDRESS <b>5703 64th Avenue</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Edmund George Van Gorden</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>June 15 19 60</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6-3-86</b>
<b>9. AGE</b> (In years last birthday) <b>74 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Pennsylvania</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William Van Gordon</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Frances Terry</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>712-18-3043</b>	
<b>17. INFORMANT</b> Address <b>Paul Britt; East Pines- Riverdale</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Acute congestive heart failure</b>  <b>4422 DUE TO</b>  <b>Cardiovascular renal disease</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>DUE TO</b>  <b>(c)</b> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>Bladensburg, Maryland.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</b>			
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>		<b>DATE SIGNED</b> <b>June 15, 1960</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>June 18, 1960</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Ft. Lincoln Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Bladensburg, Maryland.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JUN 20 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your use.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



7305

## CERTIFICATE OF DEATH

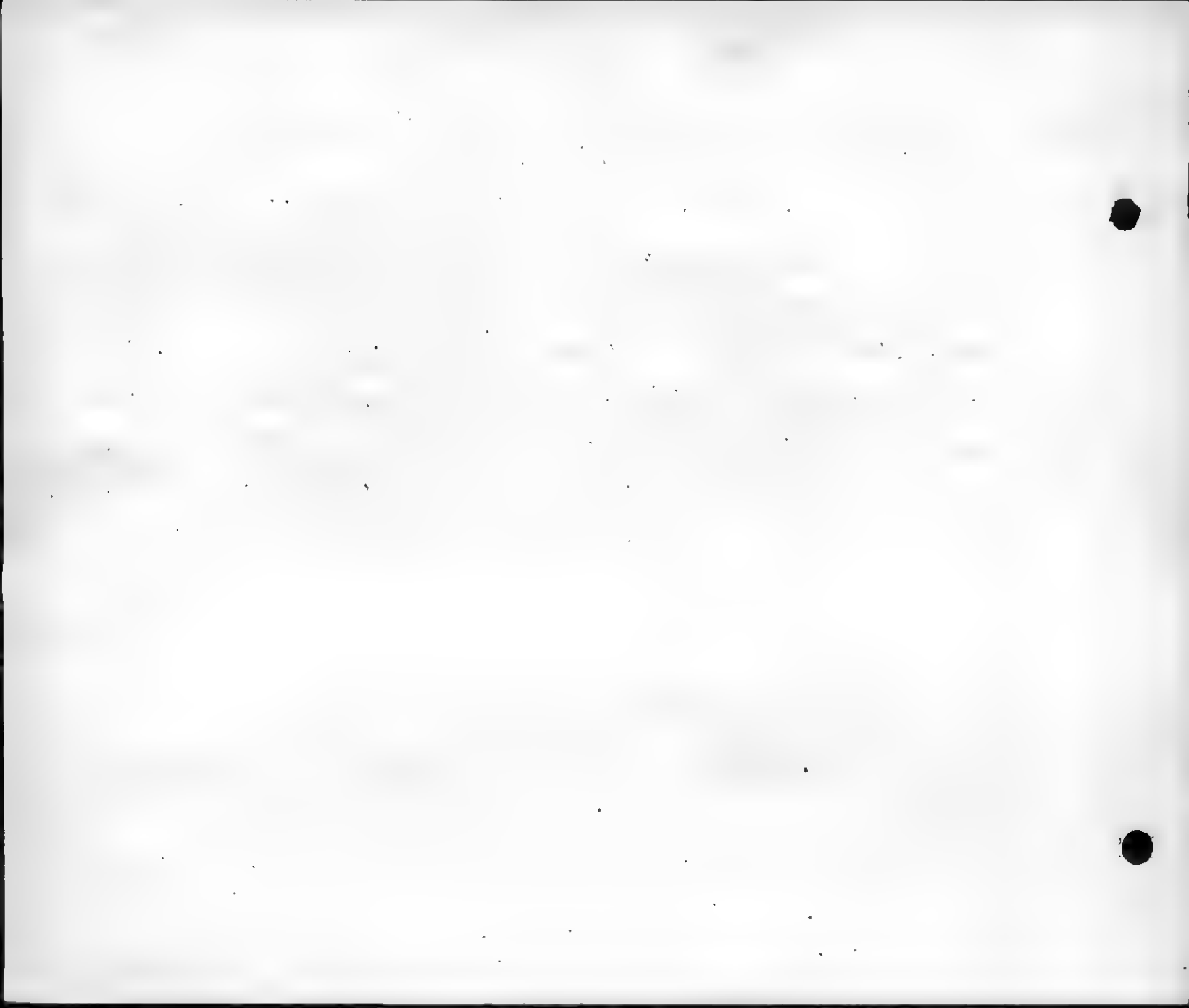
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS, WASH 25 DC</b>		d. STREET ADDRESS <b>2608 CUMMER MILLS Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>E</b> Last <b>WALKE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 SEPTEMBER 1909</b>
9. AGE (In years last birthday) yrs. <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SERVICE</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALEXANDER C. WALKE</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE GRACE GLENN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>578-40-0921</b>	
17. INFORMANT <b>WIFE</b>		Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM</b> L-200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>15 HOURS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>16 JUNE, 1960</b> to <b>17 JUNE, 1960</b> , that I last saw the deceased alive on <b>17 JUNE, 1960</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles S. Moon</b> M.D.		ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> DATE SIGNED <b>17 JUNE 60</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES S MOON, CAPT USAF (MC)</b>		<b>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JUNE 20, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>EVERLY-WHEATLEY</b>		24. REGISTRAR'S SIGNATURE <b>ALEXANDRIA, VA</b>	
ADDRESS <b>1500 W. BRADDOCK</b>		DATE <b>JUN 21 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7251

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07281

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 MT RANIER</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		d. STREET ADDRESS <u>4016 27th ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CORA</u> First <u>L</u> Middle <u>WALL</u> Last		4. DATE OF DEATH <u>JUNE 23 1960</u> Month <u>JUNE</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-97</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charlie H. Hodge</u>		14. MOTHER'S MAIDEN NAME <u>Mattie L. Renfrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Helen F. Beasley</u>		Address <u>3000 39th St. N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>SIX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hours</u> <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u> (b) <u>Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 13, 1960</u> , to <u>JUNE 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1960</u> , and that death occurred at <u>3:25 P.</u> M., from the causes and on the date stated above			
22a. SIGNATURE <u>Samuel J. Sugar</u> M.D.		22b. DATE SIGNED <u>June 13, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL J. SUGAR MD</u>		22d. ADDRESS <u>4300 KAYWOOD DR MT RANIER, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6/25/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>JUN 27 '60</u>	

17 2

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7252

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, give name of institution and residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>K.</b> Last <b>Wangler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1960</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1903</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>10</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William H Keith</b>		14. MOTHER'S MAIDEN NAME <b>Martha M Garges</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>John G Wangler</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>54 yrs. Sudden death</b> DUE TO (b) <b>gastrointestinal</b> DUE TO (c) <b>illness</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a m</b> 19 p. m		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1960</b> to <b>June 16, 1960</b> , that I last saw the deceased alive on <b>June 15, 1960</b> , and that death occurred <b>2:45 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Walcott L. Etienne</b>		ADDRESS (Street, city or town, state) <b>4713 Berwyn Road</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Walcott L. Etienne</b>		DATE SIGNED <b>June 16, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 20, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

76



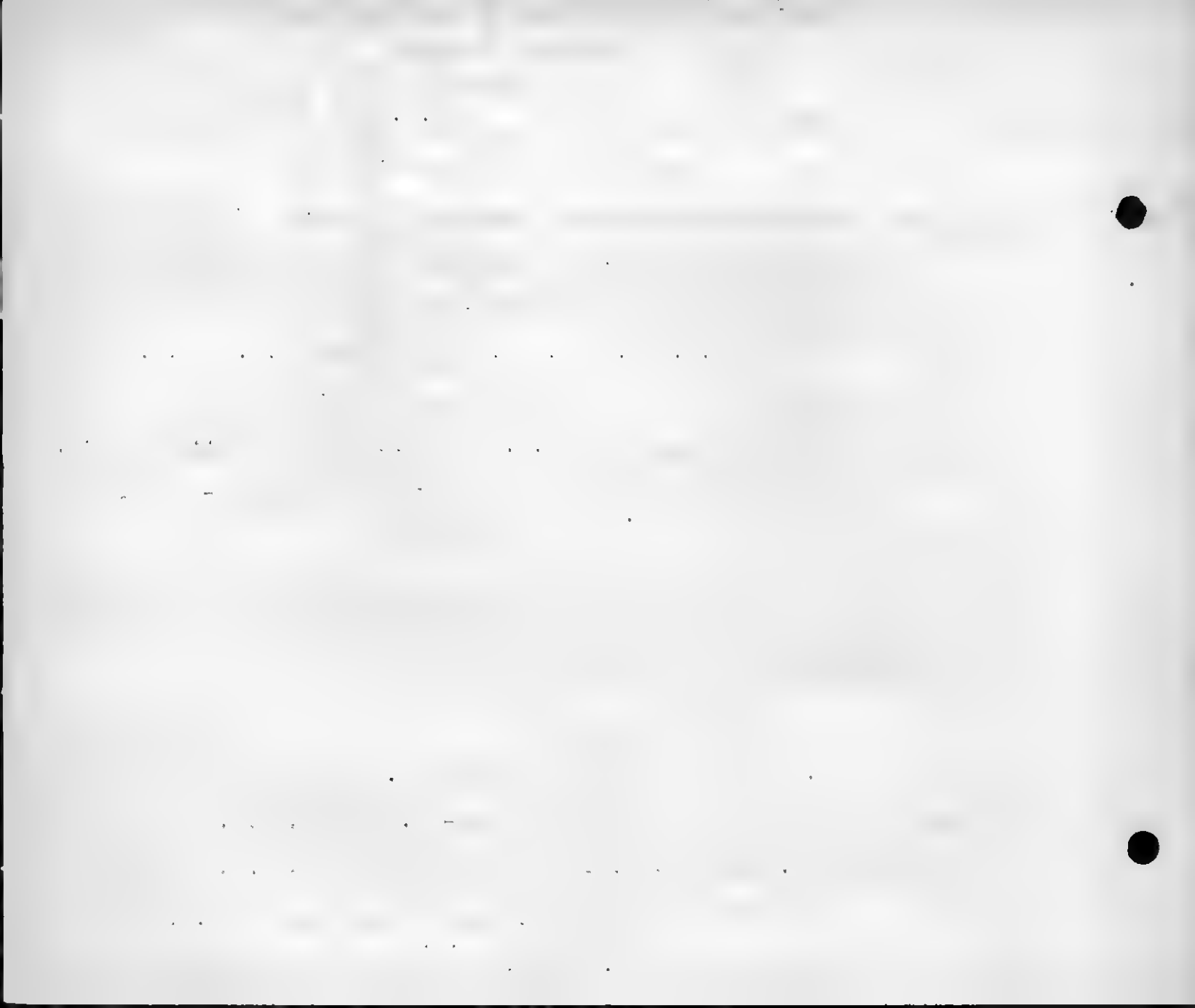
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7199

## CERTIFICATE OF DEATH

Reg. Dist. No. 07283

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor, 4922 LaSalle Road		d. STREET ADDRESS 3200 - 16th Street NW	
3. NAME OF DECEASED (Type or print) First Regina Middle C. Last Watkins		4. DATE OF DEATH Month June Day 1, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical-Supervisor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. Dept. Int.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicholas Watkins,		14. MOTHER'S MAIDEN NAME Mary Ann Foley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Sr. M. Bernedette Joseph, Carroll Manor.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2161x Coronary Thrombosis with Myocardial Infarction. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 4 weeks 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/18/1958, 19____, to 6/1/1960, 19____, that I last saw the deceased alive on 6/1/1960, 19____, and that death occurred at 9:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins		ADDRESS (Street, city or town, state) 322- H. Street, N.E.	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		DATE SIGNED 6/2/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery,		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	
DATE JUN 7 '60			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

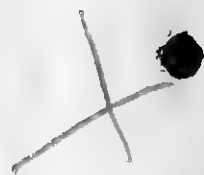
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07284

7306

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hill</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6398 Temple Hill Road</b>		/d. STREET ADDRESS <b>6398 Temple Hill Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>William</b> Last <b>Weil</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1897</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick W. Weil</b>		14. MOTHER'S MAIDEN NAME <b>Mary Slatford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578 09 4502</b>	
17. INFORMANT <b>Mildred W. Weil; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Shotgun wound of chest</b> DUE TO (c) <b>Self inflicted wound.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Self inflicted wound.</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted wound.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6-15-60</b> Hour <b>2:00</b> P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Temple Hill Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 15, 1960</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington NATL.</b>		22d. LOCATION (City, town, or county) (State) <b>Switzland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros.</b>		24a. REC'D BY REGISTRAR <b>WASH DC</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>		24c. DATE <b>JUN 17 '60</b>	



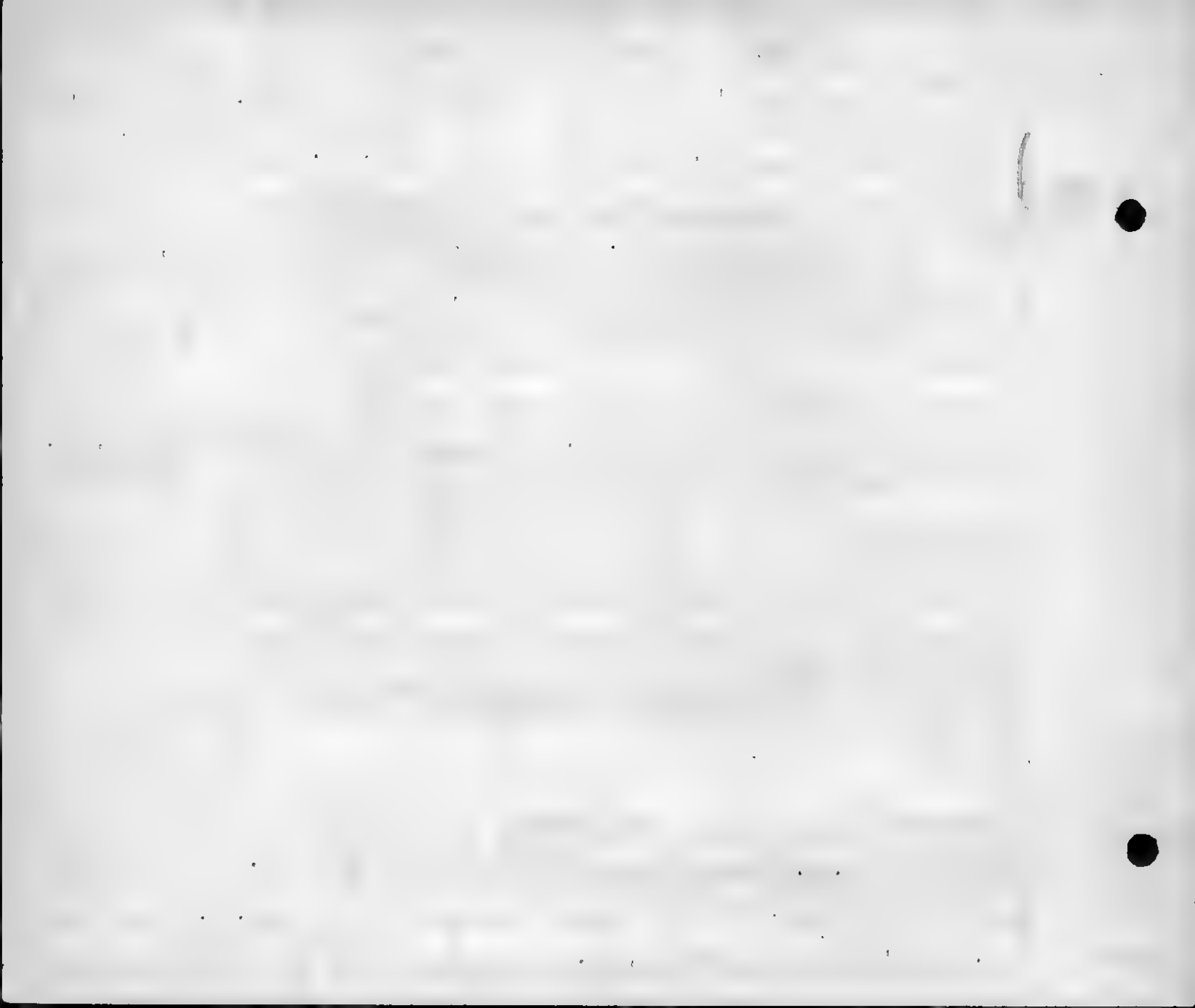
7200

CERTIFICATE OF DEATH

07285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>		c. LENGTH OF STAY IN IS <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5512 Taylor Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>L.</b> Last <b>Wheatley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Matthew Kehoe</b>		14. MOTHER'S MAIDEN NAME <b>Emma White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>H. Winship Wheatley Jr</b>		Address <b>University Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart failure</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-24</b> , 19 <b>58</b> , to <b>6-4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>5-4</b> , 19 <b>60</b> , and that death occurred at <b>3-34</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DOR Purdie</b> M.D.		ADDRESS (Street, city or town, state) <b>4404 Greenway Rd. Riverdale Md.</b> DATE SIGNED <b>6/5/60</b>	
PHYSICIAN'S NAME (Type) <b>D. R. Purdie</b>		<b>Riverdale Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 8, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 8 '60</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No. **07286**

7253

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>H.</b> Last <b>Wilhelm</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-26-86</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kanns Dept Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wrapper Ret.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles L. Huff</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Parr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577 07 3319</b>	
17. INFORMANT <b>Earl Burette-Son</b>		18. ADDRESS <b>817-51st St. Cap. Hghts, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22</b> , 19 <b>60</b> , to <b>June 23</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>60</b> , and that death occurred at <b>10:40 am</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin</b> M.D.		ADDRESS (Street, city or town, state) <b>6124 Antietam Ave</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		DATE SIGNED <b>6/23/60</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>XXXXX</b>		22b. DATE THEREOF <b>6/27/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Wm. Lee's Funeral Home</b>		ADDRESS <b>300-4th St. N.E.</b>	
24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. S. S. S.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7

1934

Private Messages

Letters

Letters changed names

and

Trans

Other files

Some 1000 copies

copies of 1000

Original transcripts

Original photographs

1000 copies of 1000

1000

William Brown  
1000 copies of 1000

1000

1000 copies of 1000



7254

## CERTIFICATE OF DEATH

Reg. Dist. No. 07287

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 H rs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph H. Williams</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W. C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-23</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR: Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Williams</b>		14. MOTHER'S MAIDEN NAME <b>Alice Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Richard Brown Lapham Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Left intra cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertensive cardiovascular disease</b> (c) <b>hypertensive cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>3:20 pm</b> on the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3717 38th St. N.E.</b> DATE SIGNED <b>6/12/60</b>			
ACTUAL SIGNATURE <b>George Hageage</b>		M.D. <b>3717 38th St. N.E.</b>	
PHYSICIAN'S NAME (Type) <b>George Hageage</b>		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-14-60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Not Harmony Cme</b>		22d. LOCATION (City, town, or county) (State) <b>Shirley Rd Ed Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Washington &amp; Son</b>		ADDRESS <b>4925 Deane Ave NE</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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